Canada Life™

Supplementary Claim Form

Instructions for completion:

1. Complete Claimant's Statement below.
2. Have your physician complete and sign reverse side of this form.
3. Return completed form to the appropriate Canada Life claims office listed below.

Claimant's Statement

Name | Loan number

1. Have you returned to work?
   - Yes, state date you returned to work — Date (day, month, year) _____
   - No, state date you expect to return to work — Date (day, month, year) _____

2. If not at work, what is your general condition at this time?

3. If not self-employed, is your employer holding your job open for you? Yes No

I hereby authorize and request all medical practitioners who may have attended me and all hospitals, government authorities, pension boards, employers or other persons to furnish The Canada Life Assurance Company or its accredited representatives all information in their possession or within their knowledge and to honour a photostatic copy of this authorization. I hereby appoint Canada Life as my agent or representative for the purpose of obtaining the above mentioned information.

Signature of insured — Date (day, month, year)

Please submit completed form to:

Creditor Insurance
330 University Avenue
Toronto ON M5G 1R8
Telephone No.: (416) 597-1440
Toll Free No.: 1-800-387-2671
Fax No.: (416) 552-6557

Attending Physician's Supplementary Statement

Instructions:

1. ***Any charge for completing this form is the patient's responsibility.***
2. *Please print.*
3. *Return completed form to your patient.*

Patient's name

1. Diagnosis of present condition

2. Objective signs *(results of recent tests and/or examinations)*

3. Indicate complications or new independent conditions which may prolong the absence from work.

4. Date of latest attendance *(day, month, year)* | Date of hospital admission *(day, month, year)* | Date of discharge *(day, month, year)*

5. Have you been actively supervising this patient's care?
   ☐ Yes, state frequency of visits ➧ ☐ Weekly ☐ Monthly ☐ Other *(specify)*
   ☐ No, please advise name(s) of attending physician(s)

6. To aid in assessing this claim, do you recall completing similar statements for other insurance companies?
   ☐ No ☐ Yes *(give insurer's name)*

7. a) Indicate present treatment program
   b) Is patient following recommended treatment program?
   ☐ Yes
   ☐ No, please comment

8. To the best of your knowledge, is the patient unable to work at own occupation?
   ☐ Yes, give approximate date when patient should be able to return to work *(day, month, year)* **or** ➧ estimated number of weeks before possible return
   ☐ No, give date patient could have returned to work *(day, month, year)* ➧

9. Physical impairment – What physical limitations affect the patient's ability to work *(eg. limitations with respect to lifting, standing, carrying, bending, walking etc.)?*

10. How long was or will patient be able to work part-time at own occupation
    From *(day, month, year)* To *(day, month, year)* **or** ➧ at light or modified duties at any occupation?
    From *(day, month, year)*

11. Remarks – Please provide comments and further details which you feel would be helpful

Name of attending physician *(please print)* | Specialty | Telephone no. *(including area code)* ( ) —

Address *(number, street, city, province, postal code)*

Signature of physician | Date *(day, month, year)*

Canadian Life and Health Insurance Association Inc.