Canada Life™

# CREDITOR PROTECTION PLAN STATEMENT OF CLAIM

ScotiaLife Financial

## CLAIM TYPE:

☐ Life ☐ Disability ☐ Hospitalization ☐ Terminal Illness

**POLICY NUMBER:** **10650**

| Business CID # | Basic Coverage Amount | Comprehensive Coverage Amount |
| --- | --- | --- |
| | $ | $ |

## INSURED INFORMATION: (PLEASE PRINT)

☐ Mr. ☐ Mrs. ☐ Ms.

First Name: ______________________ Last Name: ______________________ Date of Birth: ______________________ (mm/dd/yyyy)

Mailing Address: ______________________________________________ (Street and Number)

City/Town: ______________________ Province: ______________________ Postal Code: ______________________

Telephone No(s): ______ ______ - ______________ ______ ______ - ______________

Name and Address of the Insured's General Practitioner: ______________________________________________

______________________________________________

Name and Address of any other physicians or hospital's consulted by Insured: ______________________________________________

______________________________________________

## COMMERCIAL CREDIT BUSINESS DETAILS: (PLEASE PRINT)

Business Name and Address: ______________________________________________

Business Telephone No.: ______ ______- ______________ Business Fax No.: ______ ______ -______________

Mailing Address: ______________________________________________ Telephone No.: ______ ______- ______________

## FOR LIFE CLAIMS: (PLEASE PRINT)

☐ Mr. ☐ Mrs. ☐ Ms.

Name of Person Claiming: ______________________ Relationship to Deceased: ______________________

Mailing Address: ______________________________________________ Telephone No.: ______ ______- ______________

**NOTE:** If no family physician has been indicated above for the insured, please provide name and address of any known physicians the deceased may have consulted. In some cases, Provincial Medical Records may be required upon receipt of the claim.

**Please continue to back of this form and complete Signature of Authorization section.**

## FOR DISABILITY CLAIMS: (PLEASE PRINT) To be completed by employer

Name of Employer: ______________________ Date Employed: (mm/dd/yyyy) __________ Date Last Worked: (mm/dd/yyyy) __________

Reason for Date Last Worked: ______________________________________________

Duties of occupation (please provide formal job description if available): ______________________________________________

______________________________________________

Date employee is expected to return to work: (mm/dd/yyyy) ______________________________________________

Completed by: (please print) ______________________ Occupational Title: ______________________

Signature: ______________________ Date: (mm/dd/yyyy) ______________________

Telephone No.: ______ ______ - ______________

**CONTINUE TO BACK OF FORM**



© The Canada Life Assurance Company. All rights reserved. Any modification of this document without the express written consent of Canada Life is strictly prohibited.

## SIGNATURE OF AUTHORIZATION TO OBTAIN INFORMATION - TO BE SIGNED BY INSURED:

At **The Canada Life Assurance Company**, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Canada Life or the offices of an organization authorized by Canada Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Canada Life. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We collect, use and disclose the personal information to administer the group benefits plan, including investigating and assessing your claim.

I authorize Canada Life, my creditor and / or plan sponsor, any healthcare or rehabilitation provider, any insurance or reinsurance companies, administrators of government benefits or other benefits programs, any person having knowledge of me or my health, and service providers working with Canada Life or the above to exchange personal information, including consultation reports, when relevant and necessary for the purpose of administering the group benefits plan including investigating and assessing my claim.

I acknowledge that the personal information is needed by Canada Life to administer the group benefits plan including investigating and assessing my claim. I acknowledge that my consent enables Canada Life to process my claim and that refusing to consent may result in delay or denial of my claim.

This consent may be revoked by me at any time by sending a written instruction. I agree that a photocopy of this authorization is as valid as the original.

**Signature of Insured or Authorized Representative:** ______________________________ Date: ____________________
(MM/DD/YY)

**Note:** If signing as an Authorized Representative please confirm the manner of Authorization.(If required, proof of authorization may be requested).

☐ Executor/Administrator of Estate ☐ Power of Attorney ☐ Co-Borrower ☐ Other ______________________________
(Please Specify)

# CLAIM FOR LIFE BENEFITS

## ATTENDING PHYSICIAN'S STATEMENT - TO BE COMPLETED BY PHYSICIAN

**(ANY FEES FOR THIS INFORMATION MUST BE PAID FOR BY THE CLAIMANT.)**

First Name of Deceased: ______________________ Last Name of Deceased: ______________________

Date of Birth: ______________________ (MM/DD/YYYY) Date of Death ______________________ (MM/DD/YYYY)

Manner of Death: ☐ Accident ☐ Suicide ☐ Homicide ☐ Natural

What was the immediate cause of death? ______________________

Please provide the **exact** date the cause of death was diagnosed. ______________________ (Please include MM/DD/YYYY)

What was the Underlying cause of death, if different than above? ______________________

Please provide the **exact** date the underlying cause of death was diagnosed. ______________________ (Please include MM/DD/YYYY)

How long did the deceased have the disease or condition prior to the date of diagnosis: ________ Years ________ Months

If cause of death is unknown, was an Autopsy Performed? ☐ Yes ☐ No

If Yes, please provide a copy of the Coroner's Report.

Physician's Remarks: ______________________

Physician's Name: ______________________ (Please Print) Signature: ______________________

Address: ______________________

Telephone No.: ______ ______- ____________ Fax No.: ______ ______ - ____________

Date: ______________________

**PLEASE SUBMIT COMPLETED FORM TO:**

**The Canada Life Assurance Company**
**Creditor Claims**
**PO Box 158, Station M**
**Halifax NS B3J 3V2**
**Tel 1.800.387.2671 Fax 1.902.423.8169**



© The Canada Life Assurance Company. All rights reserved. Any modification of this document without the express written consent of Canada Life is strictly prohibited.