



CRITICAL ILLNESS CLAIMANT'S STATEMENT

Please print in ink. Incomplete forms will be returned.

Claimant name	Plan number	Division number	Plan member I.D. number
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Address (number, street, city, province, postal code)

Date of birth (dd/mm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Undisclosed <input type="checkbox"/> Female <input type="checkbox"/> Other	Phone number (including area code) () —
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Claim and Related Details

1. Please describe the nature and extent of your critical illness: _____

On what date was your condition diagnosed or surgery performed? Date (dd/mm/yyyy) _____

2. On what date did symptoms start? Date (dd/mm/yyyy) _____

Please describe these symptoms: _____

3. On what date did you first consult a medical practitioner in connection with your illness? Date (dd/mm/yyyy) _____

Please indicate the name and address of the physician seen:

Name	Phone number (including area code) () —
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Address (number, street, city, province, postal code)

4. Have you undergone any tests or investigations related to the diagnosis? If yes, please provide details and dates:

5. Have you previously suffered from, or received treatment for, a similar or related condition? Yes No

If yes, please give details, including dates: _____

Medical Consultations

1. Please provide the name and address of your personal physician:

Name

Phone number (including area code)

() —

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

2. Please provide details of any physicians who have been consulted in connection with your illness:

Name	Address (number, street, city, province, postal code)	Phone number (including area code)	Dates seen (dd/mm/yyyy)
		() —	
		() —	
		() —	

3. If you have been treated at a hospital or similar institution, please supply the following information:

Name of hospital	City or town	Date of admission (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)

4. What other treatment have you received and are you currently receiving for your condition? (e.g., medications, therapy)

Type of treatment	Institution	Prescribing physician	Dates (dd/mm/yyyy)

General

1. Has any blood relative suffered from a similar or related condition? Yes No If yes, please indicate:

Relationship	Nature of illness	Age at which illness was first diagnosed

2. Are you insured for benefits related to this condition from another company? Yes No If yes, please indicate:

Name of insurer	Type of benefit	Amount of benefit insured \$	Has a claim been submitted? <input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Do you smoke or use tobacco products?

Yes If yes, please indicate amount per day: _____ How long have you used tobacco? _____

No If no, did you previously use tobacco products? Yes No

On what date did you quit? (dd/mm/yyyy) _____

4. Please provide any further information that might be helpful in support of your claim:

Authorization and Declarations:

I authorize:

- Canada Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with Canada Life to exchange personal information, when necessary for the purpose of assessing my claim, and administering the group benefits plan;
- Canada Life to release information about my claim to an auditor authorized by my employer, plan sponsor or their agent and Canada Life at any time for the purpose of auditing the assessment of the claims;
- Canada Life to use my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan.

Except for audit purposes, this authorization shall remain valid for the duration of my claim for benefits or until otherwise revoked by me.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

I declare that the statements provided in this claim form and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as a result of a claim.

Print name _____ Signature _____

Date _____ Phone number _____

Protecting Your Personal Information

At Canada Life, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Canada Life or the offices of an organization authorized by Canada Life. 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. We use the personal information to determine your insurability and to administer the group benefits plan.

Notice About Medical Information Bureau

Important Notice

Your personal information will be treated as confidential. Canada Life or its reinsurer(s) may, however, make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another bureau member company for life or health insurance or submit a claim for benefits to such a company, the bureau will, upon request, supply the company with the information it may have.

Canada Life or its reinsurer(s) may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom you submit a claim for benefits. The company will not, however, reveal to another company or to the bureau the action taken on the basis of your current request for insurance.

If you wish to see the information in your bureau file or have it corrected, please contact the bureau's information office at:

Suite 501
330 University Ave.
Toronto ON M5G 1R7
Phone: 416.597.0590

The Canada Life Assurance Company

Critical Illness Unit

330 University Ave.
Toronto ON M5G 1R8
Toll Free: 1.866.907.2395
Fax: 416.552.6557

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