Critical Illness Insurance Claim

When should a Critical Illness Insurance claim be made?

- If you are insured under Critical Illness Insurance for CIBC Mortgages, and
- You have suffered a Critical Illness as defined in your Certificate of Insurance

What information is required for a Critical Illness Insurance claim?

☐ The following sections of this claim form: **Banking Centre Statement, Claimant Statement** and the **Attending Physician Statement**; and

☐ If the insured client is deceased, the original or notarized copy of proof of death.

- Once all sections are complete, mail or fax the document(s) to:
- **CIBC Insurance, P.O. Box 3020, Mississauga STN A, Mississauga, ON L5A 4M2**
- **Fax# 1 877 735-4900 or 905 306-4900**

Note: Any missing information may cause your claim to be delayed

What happens after a Claim is submitted?

- You are responsible for your Mortgage loan payments and insurance premiums until the claim is approved;
- You will be advised if further information is required to process your claim;
- On approval of your claim, The Canada Life Assurance Company (Canada Life) will make your benefit payment to CIBC. A notice will be sent to you indicating the payment made;
- If your claim is denied Canada Life will advise you in writing.

Do you need more information?

- Refer to your Certificate of Insurance for information about the terms, conditions, limitations, exclusions and other provisions of your coverage,
- ***Call the Creditor Helpline at 1 800 465-6020***
- ***You may contact Canada Life at 1 800 387-4495 or visit www.canadalife.com***

Your Privacy Matters - a note from the Insurers

- Creditor Insurance for CIBC Mortgages is underwritten by The Canada Life Assurance Company (Canada Life). This insurance product is administered by Canada Life and CIBC, and is subject to certain terms, conditions, limitations and exclusions, which are set out in the Certificates of Insurance, which are provided upon enrolment.
- When you requested coverage, you gave Canada Life personal information about yourself, which Canada Life added to a client file. The purpose of this file, which is strictly confidential, is to allow Canada Life and their reinsurers to conduct all the necessary business of insurance, including, setting fair premiums, receiving payments, assessing and paying claims, and keeping you informed of the status of your coverage. Canada Life keeps client files at their head office or at another secure location authorized by Canada Life.
- Only authorized personnel have access to personal information about you. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. If you want to know or correct any personal information in your claim file, just call the Creditor Helpline at **1 800 465-6020** and we will be happy to assist you.

Banking Centre Statement *(Banking Centre use only)*

Complete this Banking Centre Statement fully (please print) and give to the Claimant to have the **Claimant Statement** and the Attending **Physician Statement** completed. If the insured person is deceased, give the form to the deceased's Authorized Representative (either the Liquidator in Quebec, or the Estate Representative in the rest of Canada as defined in the respective Estate Reference Guide). Questions? Call the Creditor Helpline at 1 800 465-6020 or email "*Creditor Helpline*".

Claimant Information

First Name	Initial	Last Name

Please complete the information below for each Lending Product

	Mortgage 1	**Mortgage 2**	**Mortgage 3**
Mortgage Number			
Is there also Life Insurance for this Mortgage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Banking Centre Information

Banking Centre Long Dater (transit/address/date)	Banking Centre Telephone No.

Date (mm/dd/yyyy)	Banking Centre Officer Name and Title	**X** Banking Centre Officer Signature (sign within box)

Please give this document to the Claimant or Authorized Representative for completion.

Claimant Statement

Claimant Information

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

First Name | Initial | Last Name

Date of Birth (day, month, year) | Gender ☐ Male ☐ Female | Telephone No.

Mailing Address (Number and Street) | City | Province | Postal Code

Claimant Authorization to Release Personal Information:

If you wish to authorize someone other than yourself (such as a family member or friend) to communicate with The Canada Life Assurance Company on your behalf with respect to your claim, please complete this Authorization Form. Communication will be limited to matters related to the claim for benefits. This authorization shall remain valid for the duration of the claim for benefits or until otherwise revoked by you.

I authorize Canada Life to communicate personal information that relates to my claim for benefits with:

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

First Name of appointed person | Initial | Last Name

Relationship | Telephone No.

Address (Number and Street) | City | Province | Postal Code

Please select one option (If no selection, medical information will not be released to the authorized appointed person)

☐ Excluding medical information ☐ Including medical information

I certify that the statements in this form are true and complete. I understand that The Canada Life Assurance Company will investigate the claim. I authorize Canada Life, its agents and service providers to collect, use and exchange personal information about me needed by it for administration and adjudication of claims and by CIBC for the purpose of administering my claim under these Group Policies, with any person or organization who has relevant information pertaining to this claim, including health professionals, institutions, investigative agencies, insurers and reinsurers and administrators of government benefits and other benefits programs. I authorize the use of my information collected in relation to this mortgage insurance claim for the purposes of reviewing and administering any other coverage I may have with respect to the insured mortgage.

A photocopy of this authorization shall be as valid as the original and shall continue to have effect throughout my claim.

Date (mm/dd/yyyy) | Name | **X** Signature (sign within box)

Attending Physician Statement *(Note: Any charge for completion of this form is the responsibility of the claimant)*

Patient Information

First Name | Initial | Last Name

Date of Birth (day, month, year) | Diagnosis

Date symptoms first appeared (day, month, year) | Exact Date of First diagnosis (day, month, year)

Has the patient ever had a similar condition? ☐ Yes ☐ No | If yes, please give details (i.e. date of first symptoms, date of diagnosis, duration, etc.) From: To:

Has the patient ever been hospitalized? ☐ Yes ☐ No | If yes, provide length of stay (day, month, year) From: To:

Hospital Name | Hospital Telephone No.

Please tell us any additional information which would help us assess this claim.

Please attach copies of all specialist consultation notes, admission/discharge records relating to the cause of claim. For the following conditions, please ensure attached documentation includes but is not limited to:

Heart Attack: ECG's from the day of event and lab results supporting diagnosis including previous and new cardiac enzyme levels.

Stroke: Diagnostic evidence supporting stroke diagnosis and current neurological deficits that have been present for over 30 days.

Cancer: Diagnostic evidence to confirm malignant neoplasm including relevant pathology report.

Name of Attending Physician | Specialty

Name of Facility (Hospital, Medical Centre)

Address (Number and Street) | City | Province | Postal Code

Telephone No | Fax No.

By signing here, you acknowledge that the answers given above are true and complete to the best of your knowledge.

X

Date (mm/dd/yyyy) | Name of Attending Physician's | Signature of Attending Physician's (sign within box)

Please return this form to your patient.