Disability or Job Loss Insurance Claim

Disability Insurance Claim

When should a Disability Insurance claim be made?

- If you are insured under: Disability Insurance or CIBC Payment Protector Insurance for CIBC Personal Loans; Disability Insurance for CIBC Personal Lines of Credit; CIBC Mortgage Disability Insurance or CIBC Mortgage Disability Insurance Plus; **and**
- You have suffered a Disability as defined in your Certificate of Insurance; **and**
- You have completed the mandatory wait period following the date of your Disability as defined in your Certificate of Insurance and you did not return to work before the next regular payment following the wait period

What information is required for a Disability Insurance claim?

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

Once all sections are complete, mail the document(s) to:
CIBC Insurance, P.O. Box 3020, Mississauga STN A, Mississauga, ON L5A 4M2

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

Job Loss Insurance Claim

When should a Job Loss Insurance claim be made?

- If you are insured under: Payment Protector Insurance for CIBC Personal Loans; or CIBC Mortgage Disability Insurance Plus; **and**
- Your employment stops or is suspended as defined in your Certificate of Insurance; **and**
- You have completed the mandatory wait period following the date of your job loss as defined in your Certificate of Insurance and you did not return to work before the next regular payment following the wait period

What information is required for a Job Loss Insurance claim?

☐ Your Record of Employment filed with Human Resources and Skills Development Canada; and

☐ Your proof of Employment Insurance or Strike Pay (Union Letter); and

☐ Your proof of unemployment benefits or copy of the Service Canada letter regarding severance package; and

☐ The following sections of this claim form: **Banking Centre Statement**, **Claimant Statement** and the **Employer Statement.**

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 Loan, Personal Line of Credit (PLC) and Mortgage Loan payments and insurance premiums until the claim is approved; any payment eligible after satisfying your applicable wait period will be reimbursed;
- You will be advised if further information is required to process your claim;
- On approval of your claim, the Insurer will make your benefit payments to CIBC as long as you continue to qualify for benefits. A notice will be sent to you indicating the payment(s) made on your behalf and the date to which payment(s) may continue;
- If your claim is denied the Insurer 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 also 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 Personal Loans, CIBC Personal Line of Credit (PLC), CIBC Mortgage Disability Insurance and CIBC Mortgage Disability Insurance Plus, are underwritten by The Canada Life Assurance Company ("Canada Life"). All plans are administered by CIBC and the respective insurers. Creditor Insurance for CIBC Personal Loans and Creditor Insurance for CIBC Personal Lines of Credit, CIBC Mortgage Disability Insurance, and CIBC Mortgage Disability Insurance Plus are 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 for your Personal Loan, Personal Line of Credit or Mortgage Loan, you gave the applicable insurer personal information about yourself, which the applicable insurer added to a client file. The purpose of this file, which is strictly confidential, is to allow the applicable insurer 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. The applicable insurer keeps client files at their head office or at another location authorized by the insurer.
- 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

Complete this Banking Centre Statement fully (please print) and give to the Claimant to have the **Claimant Statement, Employer Statement** and the **Attending Physician Statement** completed.

Questions? Call the Creditor Helpline at 1 800 465-6020 or e-mail *"Creditor Helpline"*.

Claimant Information

First Name	Initial	Last Name	Date of Birth *(day, month, year)*	Gender ☐ Male ☐ Female
Mailing Address: *(Number and Street)*		City	Province	Postal Code

Please complete the information below for each Lending Product

	Lending Product 1	**Lending Product 2**	**Lending Product 3**
Lending Product *(Loan, PLC or Mortgage Loan)*			
Account Number			

Banking Centre Information

Date *(day, month, year)*	Banking Centre Officer Name and Title *(please print)*	**X**	Banking Centre Officer Signature
Banking Centre Telephone No.	Banking Centre Long Dater *(transit/address)*		

Please give this document to the Claimant for completion.

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

CLAIMANT STATEMENT - Section 1

Claimant Information

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.				
First Name	Initial	Last Name	Date of Birth *(day, month, year)*	Gender ☐ Male ☐ Female
Mailing Address: *(Number and Street)*				
City		Province	Postal Code	Telephone No.
Occupation at date of Disability/Unemployment				
Brief job description			Self-Employed ☐ Yes ☐ No	
Employment Type ☐ Full-time ☐ Part-time ☐ Seasonal ☐ Temporary			If seasonal, regular months of employment From: To:	
Name of Employer at time of Disability/Unemployment				
Address *(Number and Street)*				
City		Province	Postal Code	Telephone No.
Start date of Employment *(day, month, year)*		Last day worked *(day, month, year)*	Date or Expected date of Return to work *(day, month, year)*	

Complete if submitting a job loss claim

Provide a list of all employers you have worked for in the six (6) months prior to taking your insurance along with the number of hours worked each week

Name and address of employer *(please attach another page if required)*	Total hours worked each week

Complete if submitting a disability claim

Provide the name of the employer you worked for prior to taking your insurance along with the number of hours worked each week

Name of Employer			
Address *(Number and Street)*			
City	Province	Postal Code	Total hours worked each week
Cause of disability: ☐ Sickness ☐ Accident	If accident, date of accident *(day, month, year)*		
Location of accident ☐ Work ☐ Elsewhere*(please specify)*			
How did the accident happen? **If Motor Vehicle Accident, include the Police report**			
If illness, date illness began *(day, month, year)*	Nature of illness or injury		
Present treatment *(medication, diets, physiotherapy, etc.)*			
Have you been hospitalized for this condition? ☐ Yes ☐ No	If Yes, provide length of stay and describe		

Hospital Name	Hospital Telephone No.		
Have you ever had same or similar condition? ☐ Yes ☐ No	If yes, please state when and describe		
Name of current family physician *(please print)*			
Address *(Number and Street)*			
City	Province	Postal Code	Telephone No.
Names and addresses of all the physicians who have treated you in the 24 months prior to becoming covered under this insurance:			

CLAIMANT STATEMENT - Section 2

Claimant Authorization Form 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 (Canada Life) 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. A reproduction of this authorization shall be as valid as the original.

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

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.			
First Name of the appointed person	Initial	Last Name	Relationship
Address: *(Number and Street)*			
City	Province	Postal Code	Telephone No.
Please select one option *(If no option is selected, 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, if my claim is for disability or job loss under Creditor Insurance for CIBC Personal Loans, CIBC Mortgage Disability Insurance, or CIBC Mortgage Disability Insurance Plus, or under Creditor Insurance for CIBC Personal Lines of Credit.
- I authorize the appropriate insurer (as indicated above), its agents and service providers to collect, use and exchange personal information about me (including consultation reports, psychologically related conditions and HIV/AIDS related conditions) 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.
- For mortgage insurance claims: 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 is as valid as the original and shall continue to have effect throughout my claim.

Date *(day, month, year)*	Name and Title *(please print)*	**X**	Signature

EMPLOYER STATEMENT

To be completed by the Employer for whom you were working at commencement of disability/unemployment. If unemployed at your date of disability, to be completed by the Employer for whom you last worked. If self-employed, to be completed by Claimant.

Name of Employer	Name of Claimant	
Employer's mailing address *(Number and Street)*		
City	Province	Postal Code
Commencement date of employment *(day, month, year)*	Date last worked *(day, month, year)*	Reason for discontinuing work
If layoff, date employee notified *(day, month, year)*	Date expected to return to work OR Date returned to work *(day, month, year)* ☐ Full Time ☐ Part Time	
Did employee receive severance? ☐ Yes ☐ No	If Yes, date severance ends *(day, month, year)*	
Occupation as of last day worked		

Type of position	Specify number of hours worked per week:	Seasonal, provide inclusive dates of employment
☐ Full-time ☐ Part-time		From: To:

For a disability claim, brief outline of job duties and physical requirements (e.g.: amount of standing, bending, lifting, sitting, etc.) Please attach a copy of job description.

Has a claim been submitted to Workers Compensation? ☐ Yes ☐ No	If Yes, indicate the office address.	
Name of insurance company (other than Worker's Compensation) providing group disability coverage for your employees. Please include Policy Number and contact person.		
Insurance Company	Contact Person	Telephone No.

I certify that according to the records of this organization the above information is correct.

Date *(day, month, year)*	Name and Title of authorized officer *(please print)*	**X**	Signature of authorized officer

Telephone No.

Please return to your employee/previous employee.

ATTENDING PHYSICIAN STATEMENT

Section 1 - Patient Authorization (Claimant to complete and sign Section 1 below before requesting Physician statement)
Patient Information

First Name	Initial	Last Name	Date of Birth *(day, month, year)*

I authorize and direct any medical practitioner, hospital, or clinic or medically related facility, Medical Information Bureau (MIB), insurance company or other organization, institution or person that has, or may in the future have, any record pertaining to me or knowledge concerning me or my health to release and obtain any personal information about me (including consultation reports, psychologically related conditions and HIV/AIDS related conditions) to or from The Canada Life Assurance Company if my claim is for disability under Creditor Insurance for CIBC Personal Loans, CIBC Mortgage Disability Insurance or CIBC Mortgage Disability Insurance Plus or under Creditor Insurance for CIBC Personal Lines of Credit for the purpose of the adjudication process or the evaluation of a claim, and CIBC as Administrator under the policies.

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

Date *(day, month, year)*	Name of the Patient *(please print)*	X	Signature of the Patient

Section 2 - Attending Physician Statement

Note: Any charge for completing this form is the claimant's responsibility.

History

Date of Diagnosis for the Disabling condition *(day, month, year)*	Date patient became disabled *(day, month, year)*
Has patient ever had same or similar condition? ☐ Yes ☐ No ☐ Unknown	If Yes, state when and describe
Is condition considered chronic? ☐ Yes ☐ No	Is condition due to injury or sickness arising from patient's employment? ☐ Yes ☐ No ☐ Unknown
What precipitated absence from work?	How long has Claimant been your patient? Years Months

Names and addresses of other treating physicians

Name	Address	Specialty

Cause of Disability

Primary Diagnosis *(including any complications)*	
Secondary Diagnosis *(if applicable)*	
Additional conditions or complications which might affect duration of absence from work	
Subjective symptoms	
Objective signs *(including results of current x-rays, EKG'S, MRI'S, CATSCANS or laboratory data and any relevant clinical findings)*. Please provide copies.	
Is the patient receiving or in need of treatment for the use of alcohol or drugs? ☐ Yes ☐ No	If yes, please advise all details of the rehabilitation program.
If relevant, blood pressure at time of latest attendance /	

Section 2 - Attending Physician (continued)

Current Functional Limitations

1. **Function**

	Degree of limitation				
	None	Slight	Moderate	Severe	Don't Know
Cognition	☐	☐	☐	☐	☐
Speaking	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Sensation	☐	☐	☐	☐	☐
Psychological	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Lifting	☐	☐	☐	☐	☐

	Degree of limitation				
	None	Slight	Moderate	Severe	Don't Know
Dexterity	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐

Please add any other functions limited by the illness or injury:

_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

Please indicate max. recommended weight _____ ☐ lb ☐ kg

2. Describe any functional limitations, physical or psychological, which you consider to be major obstacles to the person's ability to work.

3. Were any functional capacity evaluations performed?	If yes, state when and type
☐ Yes ☐ No	

Treatment

Date of first visit for the disabling condition *(day, month, year)*	Date of latest visit for the disabling condition*(day, month, year)*
Frequency of visits ☐ Weekly ☐ Monthly ☐ Others *(Specify)*	
Nature of treatment *(including surgery, physiotherapy and medications prescribed, if any)*	
To your knowledge is patient following recommended treatment program? ☐ Yes ☐ No	If No, please comment

Progress

Has patient ☐ Recovered ☐ Improved ☐ Not Improved ☐ Retrogressed
Please comment:

Prognosis

If patient is pregnant, please indicate estimated date of delivery	
Is patient now totally disabled from own occupation? ☐ Yes ☐ No	If **Yes**, State date you think patient will be able to resume work *(day, month, year)* If **No**, State date patient was able to work *(day, month, year)*
If indefinite, estimate: ☐ 1-3 Months ☐ 4-6 Months ☐ Over 6 Months ☐ Never	
Is patient a suitable candidate for some trial employment or rehabilitation? ☐ Yes ☐ No	If **Yes**, state date *(day, month, year)*

Section 2 - Attending Physician (continued)

Has patient been referred to another doctor? ☐ Yes ☐ No	If Yes, date referred *(day, month, year)*	
Name	Speciality	
Mailing address *(Number and Street)*		
City	Province	Postal Code
Telephone No	Fax No.	

The patient is responsible for securing this form and for any charges made for its completion.

Name of Attending Physician *(please print)*	Specialty	
Name of Facility *(Hospital, Medical Center)*		
Mailing 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 *(day, month, year)*	Name of the Attending Physician *(please print)*		Signature of the Attending Physician

Please return this form to your patient.