Claim Form
Disability or Job Loss Claim

Disability Claim

When should a Disability Claim be made?

- you are insured under: Disability Insurance for 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 Claim?

A copy of

- ☐ the Insurer Approval letter (only if medical underwriting was required for approval of coverage), and
- ☐ the following sections of this claim form:
  Branch Statement, **Claimant Statement**, **Employer Statement** and the **Attending Physician Statement**.
  Once all sections are complete, mail the document(s) to:
  Creditor Customer Service, P.O. Box 3020, Mississauga STN A, Mississauga, ON L5A 4M2

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

Job Loss Claim

When should a Job Loss claim be made?

- you are insured under: CIBC 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. You did not return to work before the next regular payment following the wait period.

What information is required for a Job Loss claim?

- ☐ your Record of Employment filed with Human Resources Development Canada, and
- ☐ your proof of Employment Insurance or Strike Pay (Union Letter) and
- ☐ the following sections of this claim form: **Branch Statement**, **Claimant Statement** and the **Employer Statement**
  Once all sections are complete, mail the document(s) to:
  Creditor Customer Service, P.O. Box 3020, Mississauga STN A, Mississauga, ON L5A 4M2

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***

Your Privacy Matters - a note from the Insurers

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.

Creditor Insurance for CIBC Personal Loans, CIBC Mortgage Disability Insurance and CIBC Mortgage Disability Insurance Plus, are underwritten by The Canada Life Assurance Company (“Canada Life”). For claims under Creditor Insurance for CIBC Personal Lines of Credit incurred on or after January 1, 2013, the coverage is underwritten by Canada Life. For claims under Creditor Insurance for CIBC Personal Lines of Credit incurred before January 1, 2013, the coverage is underwritten by Sun Life Assurance Company of Canada (“Sun 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.

Branch Statement
Disability or Job Loss Claim

Complete this Branch Statement fully (please print) and give or forward to 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".*

Name of Insured – First Name

Last Name

Branch address and Transit no.

Branch telephone no. – –

Fax no. – –

Remarks

X

Print name

Signature of authorized officer

Date (day, month, year)

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)			
Class Loan Number, PLC Number or Mortgage Loan Number			
If medical underwriting was required for approval of coverage, please enclose a copy of the Insurer Approval Letter.			

Please give this document to the Claimant for completion.

Once **ALL** sections are complete, mail this document to:
Creditor Customer Service,
P.O. Box 3020,
Mississauga STN A,
Mississauga, ON L5A 4M2

Claimant Statement
Disability or Job Loss Claim

Claimant information

☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss First name | Last name | Date of Birth (dd mm yy)

Mailing address: Number | Street | City | Province | Postal code | Telephone no. – –

Occupation at date of Disability/unemployment | Preferred correspondence language ☐ English ☐ French | Self-employed ☐ Yes ☐ No

Employment type ☐ Full-time ☐ Part-time ☐ Seasonal ☐ Temporary | If seasonal, regular months of employment *(day, month, year)* From To

Brief job description

Name and address of employer *(at time of Disability/unemployment)* | Telephone no. – –

Last day worked (dd mm yy) | Date returned to work (dd mm yy) | Expected date of return to work (dd mm yy)

For Job Loss claims, 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

For Disability claims, name the employer you worked for 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

Are you currently receiving or will you become entitled to receive any benefits by reason of your Disability or unemployment from any of the following?

☐ Workers' Compensation Board and Reference No. ☐ E.I. *(provide date you registered for E.I. benefits & proof of approved benefits)* ☐ Canada or Quebec Pension Plan

☐ Any other group coverage *(provide company name and policy no.)* ☐ Individual insurance coverage *(provide company name and policy no.)*

Complete if submitting a disability claim

Cause of disability: ☐ Sickness ☐ Accident | If accident, provide date of accident *(day, month, year)* | Location of accident ☐ Work ☐ Elsewhere (specify):

How did accident happen/cause of Disability **If MVA, include the Police report**

Date illness began *(day, month, year)* | Nature of illness or injury

Present treatment *(medication, diets, physiotherapy, etc.)*

Have you been hospitalized for this condition? ☐ No ☐ Yes, name of hospital: | Dates hospitalized *(day, month, year)* From To

Have you ever had same or similar condition? ☐ No ☐ Yes, state when and describe:

Names and addresses of all physicians that have treated you in the last 12 months prior to taking out this insurance. Please indicate who your current family physician is.

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 and my claim was incurred on or after January 1, 2013. If my claim is for disability under Creditor Insurance for CIBC Personal Lines of Credit and was incurred before January 1, 2013, I understand that Sun Life Assurance Company of Canada ("Sun Life") will investigate the claim. 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. In particular, for any claim under Creditor Insurance for CIBC Personal Lines of Credit where the coverage was applied for prior to January 1, 2013 and the claim was incurred on or after January 1, 2013, I authorize Sun Life to transfer personal and health information to The Canada Life Assurance Company for the purposes set out above.

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 (dd mm yy)

Once this section is complete, please have page 4 completed by your employer.

X
Signature of Insured

Employer Statement
Disability or Job Loss Claim

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 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 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 *(day, month, year)*
☐ Full-time ☐ Part-time

OR

Date returned to work *(day, month, year)*
☐ Full-time ☐ Part-time

Did employee receive severance?
☐ No ☐ Yes, date severance ends *(day, month, year)*

Occupation as of last day worked

Type of position

☐ Full-time, specify number of hours worked per week:

☐ Part-time, specify number of hours worked per week:

Seasonal, provide inclusive dates of employment: *(day, month, year)*
From: To:

Brief outline of job duties and physical requirements – applies to disability claims only *(e.g.: amount of standing, bending, lifting, sitting, etc.)* Please attach a copy of job description.

Has a claim been submitted to Workers Compensation?
☐ No ☐ Yes 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.

Name of authorized officer *(please print)*

Title

Telephone no. – –

Date (dd mm yy)

X

Signature of authorized officer

Please return to your employee.

Attending Physician Statement
Disability Claim

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

☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss First name ____ Last name ____ Date of Birth (dd mm yy) ____

Mailing address: Number Street City Province Postal code ____ Telephone no. – –

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 and my claim was incurred on or after January 1, 2013, or to or from Sun Life Assurance Company of Canada if my claim is for disability under Creditor Insurance for CIBC Personal Lines of Credit and was incurred before January 1, 2013, 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 (dd mm yy)

X ____ Patient's Signature

Section 2 - Attending Physician Statement *Any charge for completing this form is the patient's responsibility.*

History

Date symptoms first appeared or accident happened *(day, month, year)* ____ Date patient became disabled *(day, month, year)* ____ Is condition due to injury or sickness arising from patient's employment? ☐ Yes ☐ No ☐ Unknown

Has patient ever had same or similar condition? ☐ No ☐ Yes, state when and describe ☐ Unknown

Is condition considered chronic? ☐ No ☐ Yes, 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 *(including any complications)*

Diagnosis

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? ☐ No ☐ Yes

If relevant, blood pressure at time of latest attendance ____ / ____

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:

	None	Slight	Moderate	Severe	Don't Know
____	☐	☐	☐	☐	☐
____	☐	☐	☐	☐	☐

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? ☐ No ☐ Yes

If "Yes", state type: ____ When? ____

Section 2 - Attending Physician *(continued)*

Treatment

Date of first visit *(day, month, year)*

Date of latest visit *(day, month, year)*

Frequency of visits
☐ Weekly ☐ Monthly ☐ Other *(specify)*

Nature of treatment *(including surgery, physiotherapy and medications prescribed, if any)*

To your knowledge is patient following recommended treatment program? ☐ Yes ☐ No, please comment:

Progress

Has patient
☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed

Please comment:

Prognosis

If patient is pregnant, please indicate estimated date of confinement

Is patient now **totally disabled** from own occupation?

☐ Yes, state date you think patient will be able to resume work: *(day, month, year)*

☐ No, state date patient was able to work: *(day, month, year)*

If indefinite, estimate:
☐ 1 - 3 months ☐ 4 - 6 month
☐ over 6 months ☐ never

Is patient a suitable candidate for some trial employment or rehabilitation?
☐ No ☐ Yes, state date
(day, month, year)

Has patient been referred to another doctor?
☐ No ☐ Yes, date referred:

Name

Specialty

Mailing address: Number, Street

Telephone No. – –

Fax No. – –

Remarks

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

Name of Attending Physician *(please print)*

Name of Facility (Hospital, Medical Center)

Mailing address: Number, Street

City

Province

Postal Code

Specialty

Telephone No. – –

Fax No. – –

Attending Physician’s Signature

Date

Please return this form to your patient.