What You Should Know About the Critical Illness Benefit Claims Process

Before submitting your claim:

- Before you submit your claim, you may wish to review your Critical Illness coverage* to ensure that the condition you wish to claim for is a condition covered by your policy.
- You may also wish to review the other terms and conditions of your Critical Illness coverage*, such as whether your policy contains a waiting period, limitations and/or exclusions.

  * The document which describes your coverage may be called an Insurance Certificate or a Summary of Insurance.

To ensure your claim is processed promptly:

- You will find enclosed claim forms that you, your physician and your employer* will need to complete, sign and return to us in order to apply for Critical Illness benefits. Please ensure that the forms have been fully completed before returning it to our office. ***The Certificate of Employer form is only required if your Critical Illness coverage is provided through your employer.**
- A Doctor of Medicine must complete the Attending Physician's Statement. As our Medical Directors do not examine you, we depend on the quality of the medical information given by your physicians to assess your claim. Please ensure that your physician includes copies of all specialist consultation, investigation and test results which confirm your diagnosis. The medical information we require is listed on the Attending Physician Statement.
- To avoid unnecessary delays, please be sure to include your policy number and policyholder name.
- We have included an authorization in addition to the claim form. By signing this authorization and declaration, you give Industrial Alliance Insurance and Financial Services Inc. (the "Company") consent to obtain information from your physicians, your employer, other insurers and health care providers and others as described in the Authorization. We will need your permission to obtain the necessary information to assess your claim.
- Submit all forms together to the Company at the address below. You may also send your claim form and authorization the fax number below. If you send your claim form by fax, please also mail the original form and authorization.
- We recommend you keep a photocopy of the completed forms and authorization for your records.
- We recommend that you submit your claim as soon as possible as there may be a time limitation on your policy.

Upon receipt of your claim:

- Once we receive your claim forms, we will send you a letter to acknowledge receipt of your claim within five (5) business days.
- We will assess your claim to determine your eligibility for benefit in accordance with the terms and conditions of your Policy.
- During the assessment of your claim, we will need to request additional information from your doctors and/or from the provincial health records, or other sources. It normally takes a few weeks to receive this information. If it takes longer than a few weeks, we will be in touch with you to see if you can help us get this information.
- **Once all of the necessary information to determine your eligibility for benefits has been received, we will notify you of our decision.**

Important notes and answers to some frequently asked questions:

- We will keep you up to date on the status of your claim as outlined above.
- You are responsible for any costs associated with providing the initial poof of claim, including the cost of medical information provided by your attending physician(s). When the Company requests information directly from your physician(s), we will offer to pay a correspondence fee for it.
- You should feel free to call us if you have any questions about your claim or the claims process. Your adjuster will be pleased to answer your questions.
- If you are unable to reach your adjuster immediately, please leave a message. We strive to return all calls within one business day.

You can contact us at:

Industrial Alliance
Insurance and Financial Services Inc.
Life and Health Claims Department
Special Markets Solutions
2165 Broadway W, PO Box 5900
Vancouver, BC V6B 5H6

Toll Free Telephone: 1-800-266-5667
Fax: (604) 733-9519

Life and Health Claims Department
Special Markets Solutions
2165 Broadway West, PO Box 5900
Vancouver, BC V6B 5H6

Claimant Statement Preliminary Proof of Loss for Critical Illness Claim A

Please print in ink

POLICY INFORMATION

Policy Number	Policyholder Name	Original effective date of coverage

☐ Individual Insurance ☐ Creditor Insurance ☐ Group Insurance

IDENTIFICATION AND CONTACT INFORMATION

First Name	Last Name	Sex ☐ Male ☐ Female

Address

Number Street Unit/Suite/Apt. No.

City	Province	Postal Code

Home Telephone Area code	Cellular Phone Area code	Work Telephone Area code

Email

Date of Birth	Provincial Health Number

Occupation	Employer Name

Date Hired	Last Day worked	Return to work or expected return to work date

INFORMATION ABOUT YOUR HEALTH

Describe the Type of Critical Illness or Type of Surgery	Date of diagnosis or surgery

Date first symptoms began	Description of first symptoms

Date of first medical visit for this condition

First doctor, hospital, and/or clinic seen:

Name of physician or clinic	Telephone Number	Address

Did you have investigations? ☐ Yes ☐ No If yes, please indicate where the investigations took place

Name of physician or clinic	Telephone Number	Address

Name of physician who made diagnosis

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Claimant Statement Preliminary Proof of Loss for Critical Illness Claim A

Names of all other physicians, specialists, clinics and hospitals seen for your condition

Name of physician or clinic	Telephone Number	Address

What treatment have you received or will you be receiving for this condition

Have you had the same, similar or related condition in the past? ☐ Yes ☐ No
If yes, please provide details & dates

Do you smoke or use tobacco products?

☐ Yes

Please indicate the amount per day: _____

How long have you used tobacco? _____

☐ No

Have you used tobacco products in the past?
☐ Yes, what date did you quit? _____
☐ No

Has any blood relative suffered from a similar or related illness? ☐ Yes ☐ No
If yes, please indicate

Relationship	Nature of Illness	Age at which Illness was diagnosed

PHYSICIAN AND HOSPITAL INFORMATION

Name of your primary personal physician/ family physician / primary medical clinic	How long have you been with this physician and/or clinic?

If you have been with your primary physician /family physician / primary medical clinic you indicated above for less than 5 years, please list all physicians, medical clinics or hospitals seen in the last 5 years

Name of physician or clinic	Telephone Number	Address

Please provide any further information which you think might be helpful in support of your claim

I hereby certify that all the information contained in this declaration is accurate and complete and that 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 the result of this claim.

Signature	Date

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Authorization and Declaration for Claim B

PROTECTING THE PRIVACY OF YOUR PERSONAL INFORMATION

At Industrial Alliance Insurance and Financial Services Inc. (the "Company"), we recognize and respect every individual's right to privacy.
Personal information about you is kept in a confidential claim file at the offices of the company or of an organization authorized by the Company in a secure area. We limit access to information in your files to the Company staff or persons authorized by the Company who require this access to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

We use this information to investigate, assess and administer your claim and the terms of the Insurance contract provisions.

You may access the personal information contained in your file and correct any inaccurate information. Any personal health information will be provided to you through a medical practitioner of your choice. To view your personal information please send a request in writing to the attention of the Claims Department at the above address, together with the name of the Medical practitioner.

AUTHORIZATION AND DECLARATION

I hereby authorize Industrial Alliance Insurance and Financial Services Inc. (the "Company"), for the purposes of investigation, evaluation and administration of my claim:

a) to gather only the information necessary for the above specified purposes from any person or organization that has personal information relating to me, including other insurers, reinsurers, and financial institutions; physicians, medical institutions and healthcare providers; employers or administrators of group benefits; agents or brokers; investigating and credit reporting agencies, and all persons or organizations likely to have personal information relevant to my claim.

b) to disclose and exchange only the necessary personal information the Company has relating to me to the above persons and organizations.

I understand that the personal information obtained by the use of this authorization will be used by the Company in the investigation, administration and evaluation of a claim for benefits. Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

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

I declare that the information provided in the Claimant's Statement is accurate 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 the result of this claim.

Claimant's Name (Please Print):_____

Signature of Claimant: _____Date:_____
(dd/mmm/yyyy)

Life and Health Claims Department
Special Markets Solutions
2165 Broadway West, PO Box 5900
Vancouver, BC V6B 5H6

Attending Physician Initial Statement for Critical Illness Benefits C

Part 1 – Patient to complete this authorization

This is not a request for examination but for information taken from your chart. The patient is responsible for securing this form and any charges for its completion.

Patient Name	Date of Birth
	Policy Number

I hereby authorize the release of any information requested on this form to the Industrial Alliance Insurance and Financial Services Inc. or any of its agents.

Patient Signature _____ Date DD/MMM/YYYY

Please print in ink

Part 2 – Physician to complete this

Diagnosis	Date diagnosis confirmed

Date of onset of first symptoms	Description of first symptoms

Date of first medical visit related to this condition	Location of first medical visit (family doctor, emergency room, walk-in clinic etc.)

In order to assist us in promptly assessing your patient's claim, **please include copies of relevant consultation reports, investigation and test results which confirm the diagnosis**, including:

For Cancer	For Heart Attack	For all other conditions
✓ Pathology reports ✓ Specialist consultation reports ✓ All other relevant reports detailing Site of Tumor Type of Tumor Size of Tumor Depth of Tumor Histology Staging Adjacent tissue invasion Lymph node involvement Metastases	✓ Specialist Consultation reports ✓ Echocardiograms ✓ Laboratory test results, including cardiac biochemical markers, cardiac enzymes ✓ Operative reports ✓ Angiographic, Echocardiogram studies	✓ Specialist Consultation reports ✓ Operative reports ✓ CT Scans, MRI, X-Rays, etc. ✓ Angiographic, Echocardiogram, Electrocardiograms studies ✓ Laboratory test results ✓ Neurological assessments ✓ All other relevant reports confirming diagnosis

Did your patient attend the Hospital Emergency? ☐ Yes ☐ No Was your patient Hospitalized? ☐ Yes ☐ No

Please attach a copy of the Discharge Summary. If not available then please indicate:

Name of Institution	Date of admission	Date of discharge

Surgery performed or planned? ☐ Yes ☐ No	Procedure	Date

Name Surgeon	Specialty (if applicable)

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Attending Physician Initial Statement for Critical Illness Benefits C

Current and planned treatment

Has the patient ever had the same or similar Condition? ☐ Yes ☐ No ☐ Unknown If yes, please provide date, diagnosis, and treatment received:

Family physician's name

Date patient was first under your care	If patient was referred to you, name the referring physician	Date Referred

Names and specialties of other physicians who are or will be involved in your patient's care

Physician Name	Specialty	Date of consultation

Have any of your patient's blood relatives suffered from the same, a similar or related illness? ☐ Yes ☐ No ☐ Unknown
If yes, please indicate:

Relationship	Nature of Illness	Age at which Illness was first Diagnosed

Does your patient currently use tobacco or a tobacco substitute? ☐ Yes ☐ No ☐ Unknown

Has your patient ever used tobacco or a tobacco substitute? ☐ Yes ☐ No ☐ Unknown

If yes, please indicate date stopped

Any other comments

Physician Name	Specialty	Phone

Address	Fax

Physician's Signature, M.D.	Date

Life and Health Claims Department
Special Markets Solutions
2165 Broadway West, PO Box 5900
Vancouver, BC V6B 5H6

Certificate of Employer for Critical Illness Benefits D

If your Critical Illness coverage is provided through your employer, please have this form completed ***Please print in ink***

SECTION 1 - EMPLOYEE INFORMATION

Employee Name	Date of Birth

Employee Address

Number Street Unit/Suite/Apt. No.

City	Province	Postal Code	Telephone Area code

Employee Occupation or Job Title	Annual Salary $

Employee Classification (i.e.: manager, executive, partner, etc.)	Check all that apply	Hours worked per week
	☐ Permanent ☐ Full Time ☐ Temporary ☐ Part Time ☐ Seasonal ☐ Other _____	

Hire Date	Last Day Worked	Last day worked due to	Return to work or expected return to work date
		☐ Disability ☐ Strike or Lockout ☐ Layoff ☐ Other_____	

SECTION 2 - POLICY INFORMATION

Policy Number	Policyholder Name

Benefit Amount $	Employee Effective Date of Coverage	Date Premiums paid to

Was employee Actively at Work on Effective Date of Coverage ☐ Yes ☐ No

If No, Reason Not Actively at Work	Date Returned to Work

SECTION 3 - EMPLOYER INFORMATION

Company Name

Company Address

Number Street Unit/Suite No.

City	Province	Postal Code

Telephone Area code Ext.	Fax Area code	Email

I certify that the information contained in this declaration is true, correct, and complete to the best of my knowledge and belief

Signature of Human Resource Officer or Authorized Officer	Date

Print Name	Title