Critical Illness Claim Form
POLICYHOLDER’S STATEMENT
PLEASE PRINT. TO SPEED UP PROCESSING, ANSWER ALL QUESTIONS.

Policyholder’s name ____________________________________________________________
Address ____________________________________________________________________ Postal code ____________
Telephone ___________________________ Email ________________________________________
Authorized person’s name ______________________________________________________

PART 1 – MEMBER INFORMATION

1. Member’s name ____________________________________________________________
2. Policy no. ___________________ Division no. _________ Class no. ______________ Certificate no. __________________________
3. Occupation ________________________________________________________________
4. Date hired ________ M ________ D __________ Certificate effective date ________ M ________ D __________
   Last day at work ________ M ________ D __________ Amount of coverage $______________
5. Please indicate any other comments relevant to this claim.
   __________________________________________________________________________
   __________________________________________________________________________

I certify the accuracy of the information above.

Authorized signature X ________ M ________ D ________________________________
CLAIMANT'S STATEMENT
TO SPEED UP PROCESSING, PLEASE ANSWER ALL QUESTIONS AND OBTAIN ALL REQUIRED SIGNATURES.

IDENTIFICATION

Claimant's name (if different from plan member) ________________________________________________________

Date of birth   Y   M   D

Plan member's name ____________________________________________________________

Certificate no.   Y   M   D   Date of birth   Y   M   D

Address ____________________________________________________________

Postal code   Y   M   D   Telephone   Y   M   D

Employer's name ____________________________________________________________

Date hired   Y   M   D   Date of onset illness   Y   M   D   Date of surgery   Y   M   D

CLAIMS AND RELATED DETAILS

1. Please indicate the type of critical illness that you are claiming.

____________________________________________________________________________________________________

2. Please give full details of the extent and nature of your illness.

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

3. Have you previously suffered from, or received treatment for, the same or a similar or related illness?

No ☐   Yes ☐   If "yes," give full details.

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

4. On what date did you first consult a doctor in connection with your illness?

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

5. Please give details of the treatment you received including details and dates of any hospital investigations or in-patient treatment.

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________
6. Have any of your blood relatives suffered from a similar or related illness? If “yes,” state relationship of relative, nature of illness and the date when the illness was diagnosed.

____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

7. Please provide names, addresses and telephone numbers of all physicians who have treated you or hospitals at which you have been treated for this illness (include dates attended).

____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

8. Please provide the name, address and phone number of your family physician.

____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

CONFIRMATION and AUTHORIZATION OF PLAN MEMBER AND CLAIMANT (if different)

I HEREBY CONFIRM that the information contained in this Claim form for a Critical Illness Benefit is true and complete to the best of my knowledge.

If this claim is being made on behalf of my spouse or dependent child, I CONFIRM that I am AUTHORIZED to disclose information about them with respect to the claim.

On behalf of myself and my dependents:

(1) I consent to the RELEASE of the information contained in this Claim form to Industrial Alliance Insurance and Financial Services Inc. (the “Company”), its employees, agents, reinsurers and service providers for the purpose of underwriting, administration and processing of the claim; and

   I UNDERSTAND AND AUTHORIZE that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, the Company will have the right to use and exchange any information related to the claim with any relevant regulatory, investigative or government body, any healthcare provider or professional medical organization, insurance company or reinsurer, the policyholder, my employer or any other party as provided by law for the purpose of investigating any such fraud or abuse.

   I UNDERSTAND that personal information may be subject to disclosure to those authorized under the applicable laws within or outside of Canada.

(2) I AUTHORIZE any healthcare provider or professional, medical organization, insurance or reinsurance company, workers’ compensation board, the policyholder, my employer, as well as any other person, public or private organization or institution to disclose to the Company, its employees, agents and service providers any information which they may need in the assessment of the claim.

I AUTHORIZE the use of my Social Insurance Number as an identification number where it is required for the administration of the group policy.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original. I understand that by furnishing this form and investigating the claim or accepting proofs of the claim, the Company shall not be held to admit the validity of the claim nor to have waived any of its rights in defence of the claim arising under the Group Policy.

Signature of plan member (mandatory) X ________________________________
Y M D

Signature of claimant (if different) X ________________________________
Y M D

LIMITATION PERIOD NOTICE

We are required under certain legislation to advise you that your claim under your group policy is governed by a limitation period that is set out in the Insurance Act or other applicable legislation in your province (e.g. Limitations Act, 2002 (Ontario), Civil Code (Quebec)). This means you cannot sue after a certain period of time has passed. You must obtain your own independent advice in regard to this limitation period.
MEMBER IDENTIFICATION (The member must complete this section)

Last name ____________________________________________  First name ______________________________________________

Policy no. ___________________________  Social Insurance Number ___________________________  Certificate no. ___________________________

Date of birth _____________________________

ATTENDING PHYSICIAN’S STATEMENT

Please print and give to the patient

PLEASE ANSWER ALL QUESTIONS AND ATTACH ANY DOCUMENTS PERTINENT TO THE ANALYSIS OF THE REQUEST

PART 1 – DIAGNOSIS

Patient last and first name ___________________________________________________  Date of diagnosis _____________________________

1. Primary __________________________________________________________________________________________________

2. Secondary __________________________________________________________________________________________________

3. The patient is a:  Smoker □  Non-Smoker □

4. For the illnesses or associated symptoms diagnosed, has the patient previously:

   received medical treatments □  consulted another physician □  taken medication □  been hospitalized □

   undergone examinations □  Specify the periods: _____________________________

PART 2 – TREATMENT

1. Medication (name and dosage): _________________________________________________________________________________

2. Has the patient undergone or will the patient undergo:

   a) Examinations or tests  No □  Yes □  Specify and provide copies of test results: _____________________________

   b) Surgery  No □  Yes □  Day surgery □  Type: _____________________________  Date: _____________________________

   Surgical procedure: _____________________________

   c) Other treatments?  No □  Yes □  Specify: _____________________________

   d) Hospitalization  From __________ to __________

   Name of hospital: _____________________________

   e) A short stay under observation (number of hours): __________

PART 3 – FOLLOW-UP AND PROGNOSIS

1. Date of first consultation for this illness: _____________________________

   Next consultation: _____________________________  Starting date of illness: _____________________________

2. Dates of other consultations: _____________________________  Follow-up frequency: _____________________________

3. Referral to another physician?  No □  Yes □  Name of physician: _____________________________

   Specialty: _____________________________

PART 4 – IDENTIFICATION OF THE ATTENDING PHYSICIAN

1. Last and first name ____________________________________________  Telephone _____________________________

2. Address ____________________________________________  Fax _____________________________

3. General practitioner □  Specialist □  Other □  Specify: _____________________________

Signature X _____________________________

Y M D _____________________________

NOTE: THE MEMBER IS RESPONSIBLE FOR ANY FEES CHARGED TO COMPLETE THIS FORM.