GROUP
INSURANCE

F54-856A(17-03)

Critical Illness Claim Form

iA Financial Group

INVESTED IN YOU.

iA Financial Group

CRITICAL ILLNESS CLAIM FORM

GROUP INSURANCE

According to your region, please submit the completed form to:

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario and Atlantic Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

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 Y M D _____ Certificate effective date Y M D _____

Last day at work Y 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** _____ Y M D _____

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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. _____ Date of birth Y M D

Address _____

Postal code _____ Telephone _____ _____

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.

_____

_____

_____

CLAIMS AND RELATED DETAILS (CONTINUED)

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 reulatory, 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.

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MEMBER IDENTIFICATION (The member must complete this section)

Last name _____ First name _____

Policy no. _____ Social Insurance Number _____ Certificate no. _____

Date of birth Y M D _____

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 Y M D _____

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: Y M D _____

Surgical procedure: _____

c) Other treatments? No ☐ Yes ☐ Specify: _____

d) Hospitalization From Y M D _____ to Y M D _____

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: Y M D _____

Next consultation: Y M D _____ Starting date of illness: Y M D _____

2. Dates of other consultations: Y M D _____ 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.