Life and Health Claims Dept.
2165 Broadway W, PO Box 5900
Vancouver, BC V6B 5H6
Telephone: 604-737-9377 / 1-800-549-7227
Fax: 604-733-9519 / 1-833-733-9519

Creditor Disability Claim Application Kit

The Application Kit contains: an instruction sheet plus forms that need to be completed in order to apply for disability benefits; and some important information about the claims process itself.

Please keep this instruction sheet for your future reference.

The Application Kit includes the following forms, which must be completed and submitted within 90 days of onset of Total Disability:

- **A** Claimant's Statement – Preliminary Proof of Loss
- **B** Authorization and Declarations
- **C** Attending Physician's Statement
- **D** { Certificate and Financial Institution Information
  Employer's Statement

Also, please provide a Copy of your Birth Certificate or Driver's License.

A. Claimant's Statement – Preliminary Proof of Loss

This form requests information of you. Please complete all sections fully. If you have additional information that has not been requested which you feel is pertinent to your claim, please provide as an attachment.

B. Authorizations and Declarations

We need your permission to obtain information that will help us assess your claim. By signing this authorization and declarations form, 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. You also confirm that any subsequent information you provide in person or by telephone will be true and complete.

C. Attending Physician's Statement

The physician from whom you are receiving treatment for your disabling condition must complete this form. It requests general information about your condition(s). You are responsible for any fees your attending physician(s) may charge for preparing the forms.

D. Certificate and Financial Institution Information

This form requests important information regarding your certificate, financial institution and loan. Please complete the applicable sections and be sure to include the Certificate Number. If you have more than one loan insured against disability with Industrial Alliance, please provide separate information in the additional section provided or on a separate sheet. This form also enables us to exchange information, of a nonmedical nature, with your dealership and financial institution.

D. Employer's Statement

Before we can assess your claim we need sections 1 and 2 completed by your employer. If you are self employed, you must complete sections 2 and 3 of this form.

Please read Page 2 for information about the Claims Process ☞

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What You Should Know
About the Claims Process

Before submitting your claim:

- Please ensure that you have read your Certificate of Insurance carefully, in particular the section entitled "LIMITATIONS AND EXCLUSIONS".
- Please ensure that you have read all of the instructions and that all of the relevant sections of the Creditor Disability Claim Application Kit have been completed by you, your employer and attending physician(s). Be sure to include a copy of your Birth Certificate or Driver's License. Incomplete or lack of information will cause delays.

To ensure your claim is processed promptly:

- Submit your claim to the Company at the address indicated at the top of the claim forms. Please do not fax the forms but send them by mail or courier.
- As our Medical Directors do not examine you, we depend on the quality of the medical information given by your physician(s) to assess your claim.
- We recommend that you submit your claim as soon as possible after the waiting period has been satisfied to avoid unnecessary delays.
- Ensure that all forms have been fully completed and enclosed.

Upon receipt of your claim:

- The Company evaluates the information included on the application forms; determines your eligibility to claim from a coverage and a Limitations and Exclusions perspective; determines if you are unable to work; and establishes an appropriate returntowork or recovery date. Our decision is based on the Certificate of Insurance provisions; your job demands and the severity of your symptoms as evidenced by the medical documentation.
- We may find it necessary to correspond directly with your physician(s) for additional medical information to assess your eligibility for benefits.
- Upon receipt of all original application forms, we will notify you within 10 business days:
- If more information is required, or
- That your claim is approved and paid, or
- If your claim cannot be processed and the reasons why.
- Once we have all the information necessary to adjudicate your claim, you will receive a letter with our decision.

Important notes and answers to some frequently asked questions:

- 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.
- A **Doctor of Medicine** must complete the Attending Physician's Statement.
- You must submit your claim within 90 days of the date you first become Totally Disabled.
- We remind you that it remains your responsibility to continue to make payments to your Financial Institution until your claim is accepted. Therefore we recommend that you contact your Financial Institution to make any arrangements ensure that you do not default on your obligation.
- If your claim is accepted, our benefit payments will be made on a "benefit month" basis, in arrears, starting one month after the benefit start date.
- Benefit payments are made directly to the Financial Institution, to reduce your financial obligation under the Loan. We notify you of any payment(s) made.
- If your condition improves or deteriorates significantly, you must notify the Company immediately.
- It is your responsibility to notify the Company of your return to work in any capacity, or your recovery.

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Claimant's Statement
Preliminary Proof of Loss for Creditor Disability Claim

A

Please print in ink

CLAIMANT

First Name | Initials | Last Name | Please Check one ❑ Mrs ❑ Ms ❑ Miss ❑ Mr

Date of Birth (dd-mmm-yyyy) | Provincial Health Care Plan | Worker's Compensation Claim ❑ Yes ❑ No

Street Address | City | Province | Postal Code

Telephone (Home) | Telephone (❑ Work ❑ Cell) | Email

OCCUPATION

Present Occupation | Date Last Worked (dd-mmm-yyyy)

Present Employer | Are you self-employed? ❑ Yes ❑ No

Briefly describe the main duties of your job and list those specific duties which you can not perform because of your disability:

Employment Type:

❑ Full-Time — Hours per week

❑ Part-Time — Hours per week

❑ Seasonal — Please provide usual months of Employment:

❑ Other — Please advise nature of employment, schedule and hours worked each week:

Please provide the name of your Employer and your occupation at the commencement of your loan:

Employer at time of Loan Commencement | Occupation at time of Loan Commencement | Telephone of Employer

Employer's Street Address | City | Province | Postal Code

DISABILITY

What medical condition is causing your disability?

Do you have any other medical condition(s)?

Date First Disabled (dd-mmm-yyyy) | Where did your Physician first attend to you? ❑ Home ❑ Office ❑ Hospital | When did your Physician first attend to you? (dd-mmm-yyyy)

Have you ever had a similar sickness or injury before? ❑ Yes ❑ No — If yes, when? (dd-mmm-yyyy) | If yes, please provide details below (i.e. surgery, edication, physiotherapy, diet, exercise, etc.)

Was your sickness or injury caused by an accident? ❑ Yes ❑ No — If yes, when did the accident occur? (dd-mmm-yyyy) | Time

If yes, what was the location of the accident? ❑ Home ❑ Work ❑ Elsewhere — If elsewhere, please specify:

Was your disability due to a motor vehicle accident? ❑ Yes ❑ No — If yes, please provide the police report # | If yes, please provide the detachment location

or enclose a copy of the Motor Vehicle Accident with this form.

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Claimant's Statement (Continued) A

Please print in ink

DISABILITY CONTINUED

Description of illness or injury (If an injury, how did it happen?)

Describe present treatment (i.e. surgery, medication, physiotherapy, diet, exercise, etc.)

Were you hospitalized? ❑ Yes ❑ No | Name of Hospital | Hospitalized **from** when? (dd-mmm-yyyy) | Hospitalized **to** when? (dd-mmm-yyyy)

Name of Physician Treating this Disability | Telephone | Fax

Street Address | City | Prov. | Postal Code

Name of Family Physician | Telephone | Fax

Street Address | City | Prov. | Postal Code

Name of Family Physician on Commencement Date of your Loan | Telephone | Fax

Street Address | City | Prov. | Postal Code

Has any other physician treated you for this Sickness or Injury? ❑ Yes ❑ No | If yes, please provide Name | Telephone

Street Address | City | Prov. | Postal Code

When did you or will you resume work?

❑ Part-Time | Date (dd-mmm-yyyy) | Time ❑ AM ❑ PM

❑ Full-Time | Date (dd-mmm-yyyy) | Time ❑ AM ❑ PM

OTHER DISABILITY BENEFIT SOURCES

Source	Claim Numbers	Claims Contact Person and Telephone Number	Benefit Amount and Frequency	First Payment (dd-mmm-yyyy)
❑ WCB or equivalent				
❑ Employer Sick Leave Plan				
❑ Group Policy with: _____				
❑ Other Sources: _____				

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

X _____ _____

Claimants Signature (must always sign) | **Date** (dd-mmm-yyyy)

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Authorization and Declarations for Creditor Disability Claim B

Please print in ink

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 the offices of an organization authorized by the Company in a secure area. We limit access to information in your files to our 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 and assess your claim and to administer the Certificate of Insurance 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.

Please sign both Authorizations and Declarations.

Authorization and Declarations

I hereby authorize Industrial Alliance Insurance and Financial Services Inc. (the "Company"), any healthcare provider, my employer, other insurance companies or other organizations, institutions, administrators of government benefits or persons possessing records or knowledge of me or benefit service providers working with the Company to release and exchange any of my personal and personal health information, when necessary to investigate and assess my claim and administer the terms of the Certificate of Insurance.

I understand that the personal information obtained by the use of this authorization will be used by the Company in the 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.

This authorization shall remain valid for the duration of my claim for benefits or until otherwise revoked by me.

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

X

Claimants Signature (must always sign) | **Claimant's Name** (Please Print) | **Date** (dd-mmm-yyyy)

Authorization and Declarations

I hereby authorize Industrial Alliance Insurance and Financial Services Inc. (the "Company"), any healthcare provider, my employer, other insurance companies or other organizations, institutions, administrators of government benefits or persons possessing records or knowledge of me or benefit service providers working with the Company to release and exchange any of my personal and personal health information, when necessary to investigate and assess my claim and administer the terms of the Certificate of Insurance.

I understand that the personal information obtained by the use of this authorization will be used by the Company in the 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.

This authorization shall remain valid for the duration of my claim for benefits or until otherwise revoked by me.

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

X

Claimants Signature (must always sign) | **Claimant's Name** (Please Print) | **Date** (dd-mmm-yyyy)

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Attending Physician's Initial Statement for Creditor Disability Benefits C

Please print in ink

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.

Name of Patient

Date of Birth (dd-mmm-yyyy)

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.

X

Signature of Patient

Date (dd-mmm-yyyy)

PART 2 PHYSICIAN TO COMPLETE THIS PART

1. **Diagnosis** (including any complications)

Primary

Secondary

If appropriate, other conditions which might affect duration of the disability:

Subjective Symptoms

Objective signs (including results of current X-rays, blood pressure, laboratory data and any relevant clinical findings):

2. **History**

Date symptoms first appeared (dd-mmm-yyyy)

Date of first visit for primary condition (dd-mmm-yyyy)

Has the patient ever had the same or similar condition? ❑ Yes ❑ No

If Yes, please state when (dd-mmm-yyyy)

If Yes, please specify diagnosis and treatment:

In order to assist in the processing of your patient's claim, it would be helpful to include a copy of your complete clinical notes for the past three years and all the relevant test results and consultation reports related to this disability. Are notes enclosed? ❑ Yes ❑ No

3. **Are you the patient's family physician?** ❑ Yes ❑ No

If yes, from what date? (dd-mmm-yyyy)

Do you have previous physician's records? ❑ Yes ❑ No

Name of Family Physician?

4. **In your opinion, when did the patient's condition first prevent him/her from working?**

Date (dd-mmm-yyyy)

5. **Current measurements of patient**

Current Height

Current Weight

6. **Treatment**

What is the current treatment regime? (i.e. drug dosage, physiotherapy, counselling, other and progress)

Please indicate all dates of visits for the current condition

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Attending Physician's Initial Statement for Creditor Disability Benefits C

Please print in ink

PART 2 CONTINUED

7. **Has your patient been fully compliant with treatment recommendations?** ❑ **Yes** ❑ **No**
   If No, please explain:

8. **If condition is due to pregnancy, what is (or was) the expected date:**
   of confinement? (dd-mmm-yyyy) | of delivery? (dd-mmm-yyyy)

9. **Is the condition due to sickness or injury arising out of the patient's employment?** ❑ **Yes** ❑ **No**
   If Yes, has your office filed a claim for this condition with the Worker's Compensation Board on behalf of your patient? ❑ **Yes** ❑ **No**

10. **Physical or Mental Impairment**
    A. **Is patient?**
    - ❑ Ambulatory
    - ❑ House confined
    - ❑ Bed confined
    - ❑ Hospital confined

    B. **If ambulatory and/or house confined, please complete the section below:**
    - ❑ Class 1 – No limitation of functional capacity; capable of strenuous activity.
    - ❑ Class 2 – Slight limitation of functional capacity; capable of moderate activity.
    - ❑ Class 3 – Marked limitation of functional capacity; capable of light activity only.
    - ❑ Class 4 – Severe limitation of functional capacity; incapable of minimal activity.

    If in Class 1, 2 or 3, explain why you believe patient cannot do his/her work:

    In your opinion, what is the earliest date your patient will be able to return to work to his/her pre-disability occupation:
    On a Full-Time basis? (dd-mmm-yyyy) | On a Part-Time basis? (dd-mmm-yyyy) | On a Modified basis? (dd-mmm-yyyy)

11. **Please provide the names and specialty of other physicians who have been/will be involved in assessing the medical problems**

12. **Hospitalization** (if applicable to this sickness or injury)
    Date of in-patient admission (dd-mmm-yyyy) | Date of discharge (dd-mmm-yyyy) | Date of out-patient treatment (dd-mmm-yyyy)
    Name of Physician

13. **Surgery**
    Surgical procedure performed | Date of Surgery (dd-mmm-yyyy)
    Name of Surgeon

14. **Any other pertinent comments**

PHYSICIAN INFORMATION

Name of Physician (Please Print) | Specialty

Street Address | City | Province | Postal Code

Telephone | Fax

X

Physician's Signature (must always sign) | **Date** (dd-mmm-yyyy)

iA Financial Group

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Certificate and Financial Institution Information for Creditor Disability Claim

D

(Claimant to complete)

Please print in ink

EMPLOYER: Complete Sections 1 and 2 and Signature at bottom **IF SELF EMPLOYED: Complete Sections 2 and 3**

Employee's Name | Job Title (Please attach a job description)

Section 1

Name of Employer

Street Address | City | Prov. | Postal Code

Employer's E-mail | Phone Number | Fax Number

Date Employee Commenced with your Company (D D / M M / Y Y Y Y)

Employment Type
❑ Full-Time ❑ Part-Time *
❑ Seasonal * ❑ Other **

Last Date Employee Worked (D D / M M / Y Y Y Y)

Annual Income
$

* If Seasonal or Part-Time, please describe below employee's schedule and average number of hours worked per week.
** If other, please describe below the nature of employment relationship, schedule and average number of hours worked per week.

Section 2

Was this a work related injury? ❑ Yes ❑ No

Has it been approved by WCB or equivalent? ❑ Yes ❑ No If Yes, provide Claim Number _____

Was the last day at work due to:

❑ Layoff ❑ Strike ❑ Lock-out ❑ Disability ❑ Other _____

Has the Employee worked any days since the date of disability? ❑ Yes ❑ No If Yes, please specify dates below

Employee's Anticipated Date of Return to Work:
Full-Time (D D / M M / Y Y Y Y) Part-Time (D D / M M / Y Y Y Y)

Section 3 – Complete if self-employed

Name of Company or Business | Nature of Business

Annual Income Average
$

❑ Sole Proprietorship ❑ Partnership ❑ Incorporated

Date your company commenced: (D D / M M / Y Y Y Y)

Are you currently performing any duties for the company?

❑ Yes ❑ No If Yes, please provide a complete description of these duties, hours worked, dates worked, and compensation received.

Are you hiring anyone to replace you while you are disabled?

❑ Yes ❑ No If Yes, please provide the person's name, address and telephone number: _____

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

Employer's Signature | Print Name in Full

Title | Date: (D D / M M / Y Y Y Y)

Claimant to complete reverse side of form ➡

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Certificate and Financial Institution Information for Creditor Disability Claim

D

(Claimant to complete)

Please print in ink

Certificate and Dealership – 1st Loan

Selling Dealership or Broker

Certificate Number

Street Address | City | Prov. | Postal Code

Date of Purchase (D D / M M M / Y Y Y Y)

Phone Number

Fax Number

Financial Institution – 1st Loan

Name

Loan Number

Street Address | City | Prov. | Postal Code

Loan Payment Day (D D)

Contact Name | Phone Number | Fax Number

Monthly Payment $

Certificate and Dealership – 2nd Loan (if more than 1 loan)

Selling Dealership or Broker

Certificate Number

Street Address | City | Prov. | Postal Code

Date of Purchase (D D / M M M / Y Y Y Y)

Phone Number

Fax Number

Financial Institution – 2nd Loan

Name

Loan Number

Street Address | City | Prov. | Postal Code

Loan Due Date (D D / M M M / Y Y Y Y)

Contact Name | Phone Number | Fax Number

Monthly Payment

I hereby authorize Industrial Alliance Insurance and Financial Services Inc. (the "Company"), to release to my financial institution or selling dealership, in relation to this Certificate of Insurance, or if more than one, Certificates of Insurance, any non-medical information regarding the status of my claim.

If you have more than two loans insured against disability with the Company, you may wish to take a photocopy of this page to provide information regarding the additional loans or simply provide it on a blank sheet of paper.

Claimant's Name (PLEASE PRINT)

Date: (D D / M M M / Y Y Y Y)

Have reverse side of form completed by Employer ➡