BMO Bank of Montreal

Line of Credit Critical Illness Insurance Claim Creditor Insurance – Policy no. 57904

Sun Life Financial

BMO Bank of Montreal Representative:

First name	Last name
Signature X	
Telephone number – –	Fax number – –
Date (dd-mm-yyyy) – –	

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What information is required for a Critical Illness claim?

Checklist for the Claimant:

☐ a completed and signed Lender's Statement
☐ a copy of the Line of Credit Insurance Application(s) pertaining to this claim
☐ a completed and signed Claimant Statement
☐ a completed and signed Attending Physician's Statement*

* Ask your doctor to complete the Attending Physician's Statement with as many details as possible. The statement should be immediately given to you to submit with your claim.

To prevent delays, please be sure the forms are fully completed and provide as much information as possible to help with the adjudication of your claim. Sun Life Assurance Company of Canada can only process your claim when we have received all of the above documents.

Please submit your claim to: Sun Life Assurance Company of Canada
Creditor Team – Disability Claims
PO Box 100 Stn C
Kitchener ON N2G 3W9

Important Notes

- Proof of claim must be submitted within 180 days of the date of diagnosis.
- Any costs for information to substantiate your claim is your responsibility.
- The Physician's Statement must be completed by a qualified Physician or Specialist practising in Canada or the United States of America.
- Please retain a photocopy of your claim forms for your records.
- Sun Life Assurance Company of Canada will inform you if your claim is subject to further investigations.
- Until Sun Life Assurance Company of Canada advises you in writing of the decision, it is your responsibility to continue paying your line of credit payments in full.
- For questions about your claim, you may call Sun Life Assurance Company of Canada at 1-877-271-8713.

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BMO Lender's Statement

Instructions – to be completed by the BMO Lender

- Give the customer the entire claim package including this Lender's Statement once it is completed.
- Provide copies of all line of credit or loan insurance applications pertaining to this claim to the customer.
- **For any Line of Credit product please also attach screen prints of the last 12 months average balances prior to the date of critical illness. Please refer to *"Inquiries – Year to date balances"* and provide a screen shot of the screen. Important: Please write the date the screen print was taken.**
- Advise your customer to send the completed claim package directly to Sun Life.
- If the coverage status on the ***"Creditor Insurance at a Glance"*** screen is **"Ineligible"** or **"Waived"** please advise the customer there is no critical illness coverage in force and do not provide a claim package.

1 Insured's information

First name	Last name	☐ Male ☐ Female	Language ☐ English ☐ French
Date of birth (dd-mm-yyyy)	Date of diagnosis (dd-mm-yyyy)	Telephone number	
Address (street number and name)		Apartment or unit number	
City	Province	Postal code	

2 Revolving Line of Credit – BMO Lenders please note that Sun Life requires all boxes in this section to be completed.

Line of Credit number
91052 _____ _____ _____

Refer to *"Loan Account Details"* screen to complete this section

Authorized limit
$

Refer to *"Inquiry – Creditor Insurance at a Glance Screen"* to complete this section

When coverage starts (dd-mm-yyyy)	Max amount covered
	$

Current balance
$

Current critical illness coverage status
☐ Active ☐ Ineligible ☐ Approved ☐ Waived ☐ Pending ☐ Terminated ☐ Cancelled ☐ Quote

3 Instalment Line of Credit – BMO Lenders please note that Sun Life requires all boxes in this section to be completed.

Line of Credit number
91052 _____ _____ _____

Refer to *"Service Navigator – Features - Renewal and Interest Rate"* screens to complete this section

Original loan amount/limit	Date opened (dd-mm-yyyy)
$	

Refer to *"Inquiry – Creditor Insurance at a Glance Screen"* to complete this section

When coverage starts (dd-mm-yyyy)	Coverage option percentage	% of critical illness payment covered
	CI _____ %	%

Current balance
$

Current critical illness coverage status
☐ Active ☐ Ineligible ☐ Approved ☐ Waived ☐ Pending ☐ Terminated ☐ Cancelled ☐ Quote

4 Insured co-borrower

Last name	First name	Last name	First name
1		5	
2		6	
3		7	
4		8	

5 Lender information

First name		Last name
Title	Transit number	Telephone number

I am an authorized representative of the Bank of Montreal and I hereby certify that the above information is true and correct.

Signature of BMO lender	Date signed (dd-mm-yyyy)
X	

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Claimant's Statement

Proof of claim must be submitted within 180 days of the date of diagnosis.

Instructions

- Print clearly in block letters.
- The "Claimant's Statement" must be fully completed, ensuring all sections are completed.
- Please indicate your line of credit number below.
- Please sign and date the Claimant Authorization.

1 Claimant information

First name		Last name	
Date of birth (dd-mm-yyyy)	☐ Male ☐ Female	Language ☐ English ☐ French	Telephone number ☐ Bus. ☐ Res.
Address (street number and name)			Apartment or unit
City		Province	Postal code
Line of Credit number			

2 Claim details

Please describe the nature and extent of your critical illness.

When was your condition diagnosed or surgery performed? (dd-mm-yyyy)	When did symptoms first commence? (dd-mm-yyyy)

Please describe the symptoms.

When did you first consult a Physician in connection with your illness? (dd-mm-yyyy)

Physician's first name	Last name	
Physician's address (street number and name)		Suite or unit
City	Province	Postal code / Telephone number

Have you undergone any tests or investigations related to the diagnosis? ☐ Yes ☐ No If *yes*, please provide details and dates.

2 Claim details (continued)

Have you previously suffered from, or received treatment for, a similar or related condition? ☐ Yes ☐ No If *yes*, please provide details and dates.

3 Medical consultations

Please provide the name and address of your personal physician.

First name	Last name	Specialty
Address (street number and name)	Telephone number	Suite or unit
City	Province	Postal code

How long has this physician been involved in your care?

Please provide details of any other physician or specialists who have been consulted in connection with your critical illness.

First name	Last name	Specialty
Address (street number and name)	Telephone number	Suite or unit
City	Province / Postal code	Date of first visit (dd-mm-yyyy)

First name	Last name	Specialty
Address (street number and name)	Telephone number	Suite or unit
City	Province / Postal code	Date seen (dd-mm-yyyy)

If you have been treated at a hospital or similar institution, please supply the following information.

Name of hospital	City or town
Date of admission (dd-mm-yyyy)	Date of discharge (dd-mm-yyyy)

What type(s) of treatment have you received, or are currently receiving, in connection with your condition? (e.g., medications, therapy, etc.).

Type of treatment	
Institution/Prescribing physician	Date (dd-mm-yyyy)

Type of treatment	
Institution/Prescribing physician	Date (dd-mm-yyyy)

3 Medical consultations (continued)

Please indicate the names and addresses of any other physicians who have treated you in the last 3 years.

First name	Last name	Specialty

Address (street number and name)	Suite or unit

City	Province	Postal code	Telephone number
			– –

First name	Last name	Specialty

Address (street number and name)	Suite or unit

City	Province	Postal code	Telephone number	Fax
			– –	– –

4 General

Have any of your immediate family (mother, father, brothers, sisters) had cancer, tumor, heart disease, diabetes, kidney disease prior to age 60? ☐ Yes ☐ No If *yes*, please indicate:

Relationship	Nature of illness	Age at which illness was first diagnosed

Relationship	Nature of illness	Age at which illness was first diagnosed

Relationship	Nature of illness	Age at which illness was first diagnosed

Are you insured for Individual Critical Illness benefits with Sun Life or with another company? ☐ Yes ☐ No If *yes*, please indicate:

Name of insurer	Policy number	Has a claim been submitted? ☐ Yes ☐ No

Are you currently receiving or have you applied for short or long term disability benefits with Sun Life? ☐ Yes ☐ No If *yes*, please indicate:

Policy number	Certificate number

Case manager's first name	Case manager's last name

Please provide any other information that would be helpful in the assessment of your claim.

5 Claimant authorization

I certify that the statements in this form are true and complete. I understand that Sun Life Assurance Company of Canada may investigate this claim. I authorize Sun Life Assurance Company of Canada, its agents and service providers (i) to collect, use, and disclose information about me (excluding health information) with the Bank of Montreal for the purpose of administering my claim and (ii) to collect, use and disclose information about me (including health information) needed for underwriting, administration and adjudicating claims under this Group Policy with any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. Further, any such person or organization is also authorized to disclose my relevant personal information to Sun Life Assurance Company of Canada, its agents and service providers. A photocopy of this authorization is as valid as the original and shall continue to have effect throughout the duration of the claim.

Signature of claimant	Date (dd-mm-yyyy)
X	– –

6 Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and telling you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

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Line of Credit Critical Illness Insurance Claim
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Attending Physician's Statement – Coronary Artery Bypass Surgery Statement

Proof of claim must be submitted within 180 days of the date of diagnosis.

Instructions

- To keep your report confidential, please mail directly to: Sun Life Assurance Company of Canada, Creditor Team – Disability Claims, PO Box 100 Stn C, Kitchener ON N2G 3W9.
- Any cost incurred for the completion of this form is the patient's responsibility.
- The purpose of this report is to assist us in making a critical illness determination. In filling out this report please include sufficient details of history, physical and diagnostic findings, clinical course, therapy and response to enable us to make this determination.

1 Patient information

IMPORTANT: Please note that you are responsible for the cost of completing this form.

Patient's first name	Last name	Date of birth (dd-mm-yyyy)
		– –

Address (street number and name)	Apartment or unit

City	Province	Postal code

Telephone number
– –

2 Physician information

Please fully complete all sections of this form. Please attach all available test results and consultation reports relevant to your patient's condition. It is your patient's responsibility for all costs in completing these forms.

When did your patient first suffer symptoms or episodes of cardiovascular disease? (dd-mm-yyyy)
– –

What were the symptoms?

When did your patient first consult you for these symptoms? (dd-mm-yyyy)	How long has this person been your patient?
– –	

Please provide the pre-operative angiography findings or a copy of the report

Please give details of the bypass surgery and surgical report, if available

Date of surgery (dd-mm-yyyy)	Which arteries were bypassed?
– –	

Name and address of hospital

2 Physician information (continued)

Name of cardiovascular surgeon, if other than yourself	Last name	
Address (street number and name)		Suite or unit
City	Province	Postal code

Please describe (including dates) any predisposing conditions or risk factors that your patient has had for cardiovascular disease.

Please give the names and addresses of other physicians consulted or hospitals attended by your patient for this or any related condition.

Is there a family history of cardiovascular disease or cerebrovascular disease? ☐ Yes ☐ No	Please provide details

Please provide any other information that would be helpful in the assessment of your patient's claim.

Please provide copies of test results (such as a copy of the pre-approved Coronary Angiography findings, the Coronary Artery Bypass operative report, discharge summaries, etc) and a copy of all consultation reports with respect to this condition.

3 Physician's authorization and signature

I certify that the information in this form is true and correct.

Physician's first name (please print)	Last name	Speciality
Address (street number and name)		Suite or unit
City	Province	Postal code
Telephone number – –	Fax number – –	
Physician's signature X		Date (dd-mm-yyyy) – –