

COMMERCIAL LOAN INSURANCE PLAN

INSTRUCTIONS TO BANK OF MONTREAL REPRESENTATIVE FOR CLAIM SUBMISSION

For Life/Accidental Dismemberment, Specific Loss and of Disability Insurance:

- Attach all copies of customer's applications for insurance
- Complete Page 2

In addition to above:

- For **life** claims attach a completed copy of the Attending Physician's Certificate (Page 6) a completed copy of the Authorization to Release Medical Information (Page 7) and either the original copy or a notarized copy of the death certificate, or the funeral certificate
- For **accidental dismemberment, specific loss or disability** claims attach a completed — Supplementary Claim Report/Attending Physician's Statement (Pages 3, 4 & 5)

Other Important Information

Claim for...	Must be submitted within...
Life (including Accidental Death)	12 months after the date of death.
Disability	30 days after: <ul style="list-style-type: none"> • the end of the waiting period.
Accidental Dismemberment/ Specific Loss	6 months after the: <ul style="list-style-type: none"> • date of loss, and or dismemberment.

LIFE/ACCIDENTAL DISMEMBERMENT, SPECIFIC LOSS, AND DISABILITY INSURANCE
CLAIM REPORT



CLEARLY IDENTIFY LOAN TYPE (Check as applicable)

- Business Loan
 - TYPE A (Commercial Mortgage/Term Loan)
 - TYPE B (Operating Loan/Line of Credit)
- Farm Loan
 - TYPE A (Commercial Mortgage/Term Loan)
 - TYPE B (Operating Loan/Line of Credit)

Provide Branch Name and Full Address below:

TYPE OF CLAIM

- Life
- Accidental Dismemberment
- Disability
- Specific Loss
-

(Please Print Clearly)

Name of Insured: _____

Address: _____

1. Date claim incurred: _____

2. Date of last Certificate of Insurance: _____

3. Amount of outstanding insured loan(s) as of (1.) above: \$ _____

\$ _____

4. Amount of accrued interest (up to a maximum of 60 days) on the outstanding insured loan at date of death: \$ _____

per diem interest rate (\$ amount) _____

5. Date of last premium payment _____

(day / month / year)

This form was forwarded via BMO Bank of Montreal by:

Contact Name: _____ Date: _____

(day / month / year)

Job Title: _____ Telephone Number: (____) _____

Signature: _____ Fax Number: (____) _____

FORWARD ALL MATERIAL TO:

**Life, Accidental Dismemberment,
Specific Loss, Claims to:**

Great-West Life Assurance Company /
The Canada Life Assurance Company
Creditor Claims Department, Floor S-3
330 University Avenue
Toronto, Ontario M5G 1 R8

Disability Claims to:

The Great-West Life Assurance Company /
The Canada Life Assurance Company
Creditor Claims Department
2001 University
Montreal, Québec H3A 1T9



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CLEARLY IDENTIFY LOAN TYPE (Check as applicable)

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 - TYPE B (Operating Loan/Line of Credit)

- Farm Loan
 - TYPE A (Commercial Mortgage/Term Loan)
 - TYPE B (Operating Loan/Line of Credit)

PART I — BORROWER'S STATEMENT

(Complete Part One and have your doctor complete Part Two)

Name of Insured: _____

Address: _____

Date illness commenced: _____

Date you ceased work because of disability: _____

If loss or disability is due to accidental injury complete the following:

Date of accident: _____

Where did accident occur? _____

How did accident occur? _____

If claiming a specific loss, please indicate what your loss is, in detail.

AUTHORIZATIONS AND DECLARATIONS

I consent, authorize and direct any physician, surgeon or any other person who has examined me and every hospital or any other institution to which I have applied for or in which I have received treatment to disclose to The Great-West Life Assurance Company / The Canada Life Assurance Company or its duly authorized representative any knowledge or information thereby acquired.

I confirm that I have read, understand and agree with the contents of the section on this form entitled "Protecting Your Personal Information."

I authorize:

- The Great-West Life Assurance Company / The Canada Life Assurance Company, any healthcare or rehabilitation provider, other insurance or reinsurance companies, other organizations or service providers working with The Great-West Life Assurance Company / The Canada Life Assurance Company to exchange personal information, when relevant and necessary for the purposes of assessing my claim, administering the plan, or performing independent assessments;
- The Great-West Life Assurance Company / The Canada Life Assurance Company to release information about my claim to an auditor authorized by BMO Bank of Montreal and The Great-West Life Assurance Company / The Canada Life Assurance Company at any time for the purpose of auditing the assessment of the claims.

Except for audit purposes, 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 statements provided in this claim report for benefits are true and complete. I agree that all such statements form the basis for any benefit approved as a result of a claim.

 Print Name

 Signature

 Date (day / month / year)

 Telephone Number

Protecting Your Personal Information

At The Great-West Life Assurance Company / The Canada Life Assurance Company, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of The Great-West Life Assurance Company / The Canada Life Assurance Company or the offices of an organization authorized by The Great-West Life Assurance Company / The Canada Life Assurance Company. You exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to The Great-West Life Assurance Company / The Canada Life Assurance Company. The Great-West Life Assurance Company / The Canada Life Assurance Company may use services providers located within or outside Canada. We limit access to personal information in your file to The Great-West Life Assurance Company / The Canada Life Assurance Company's staff or person authorized by The Great-West Life Assurance Company / The Canada Life Assurance Company who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your Personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We collect, use and disclose the personal information to administer the plan, including investigation and assessing claim, and creating and maintaining records concerning our relationships. The Great-West Life Assurance Company / The Canada Life Assurance Company or its reinsurer may also release information to other life insurance companies to whom you apply for life or health insurance or to whom you submit a claim for benefits. The company will not, however reveal to another company the actions taken on the basis of your current request for insurance. For a copy of our privacy Guidelines, or if you have any questions about our personal information policies and practices (including with respect to service providers), write to The Great-West Life Assurance Company / The Canada Life Assurance Company's Chief Compliance Officer or refer to www.greatwestlife.com or www.canadalife.com

PART II — ATTENDING PHYSICIAN'S STATEMENT FOR ACCIDENTAL DISMEMBERMENT, SPECIFIC LOSS, OR DISABILITY CLAIM
(The borrower is responsible for the completion of this form)

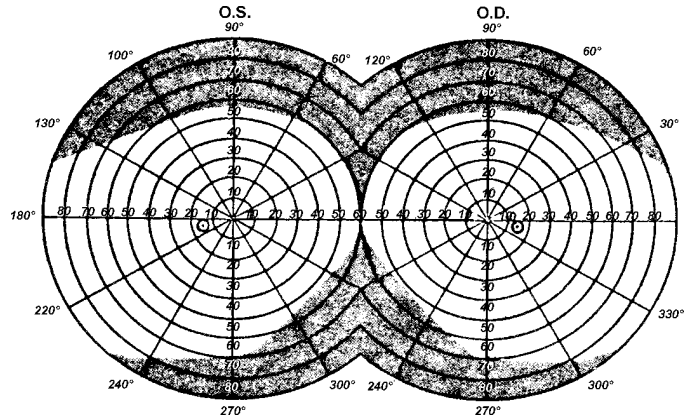
1. HISTORY (a) When did symptoms first appear or accident happen? _____ (day / month / year) (b) Date insured ceased work because of disability. _____ (day / month / year) (c) Has insured ever had same or similar condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", when: _____ (day / month / year) Describe: _____
2. DIAGNOSIS: Primary - Please provide full details. How did the accident occur? Describe. Secondary - Please provide full details. How did the accident occur? Describe.
3. PRESENT CONDITION (a) Subjective symptoms
(b) Objective findings
(c) Is insured: Ambulatory? <input type="checkbox"/> Bed confined? <input type="checkbox"/> House confined? <input type="checkbox"/> Hospital confined? <input type="checkbox"/> If Hospital confined From _____ (day / month / year) to _____ (day / month / year)
4. TREATMENT Date of (a) first visit _____ (day / month / year) Date of last visit _____ (day / month / year) (b) Frequency of visits Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____ When did you last examine the insured? _____ (day / month / year) (c) Medications Prescribed _____
5. Please describe complications, recent surgery or new independent condition(s) which are contributing to the duration of disability.
6. PROGRESS Recovered <input type="checkbox"/> Improved <input type="checkbox"/> No improvement <input type="checkbox"/> Retrogressed <input type="checkbox"/> PROGNOSIS: When should patient be able to resume work? _____ (day / month / year)
7. Include copies of test results (X-Rays, E.K.G.'s or any other special tests)
8. Has insured been referred to any doctors or a specialist? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes" then provide full name and mailing address below. _____ _____
9. Please indicate if accidental dismemberment, specific loss, or disability is a result of: <input type="checkbox"/> a. Intentional, or self inflicted <input type="checkbox"/> b. committing or intending to commit a criminal act <input type="checkbox"/> c. Medical or surgical treatment <input type="checkbox"/> d. none

10. VISUAL IMPAIRMENT

(SNELLEN NOTATION)

(a) What was vision at last observation? With Glasses — O.D. _____ O.S. _____ (day / month / year) _____
 Without Glasses — O.D. _____ O.S. _____ (day / month / year) _____

(b) If fields of vision are contracted, show contraction on chart



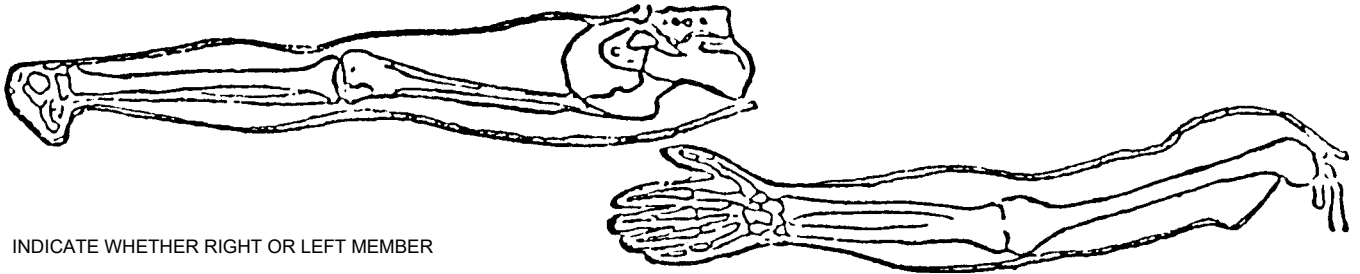
(c) Date **corrected** vision was irrecoverably reduced to 20/200 or less in the better eye

O.D. _____ O.S. _____ (day / month / year) _____

(d) Vision can be restored in whole or in part by

O.D. Lenses	<input type="checkbox"/>	Treatment	<input type="checkbox"/>	Operation	<input type="checkbox"/>	Not restorable	<input type="checkbox"/>
O.S. Lenses	<input type="checkbox"/>	Treatment	<input type="checkbox"/>	Operation	<input type="checkbox"/>	Not restorable	<input type="checkbox"/>

11. NOTE: If dismemberment has occurred, please indicate the point of amputation on diagram below. Indicate Right, Left, or Both Members.



(Please Print Clearly)

DATE (day / month / year)

FULL NAME

SIGNATURE

COMPLETE MAILING ADDRESS

ATTENDING PHYSICIAN'S CERTIFICATE
FOR LIFE CLAIMS



COMMERCIAL LOAN INSURANCE PLAN

(Please Print Clearly)

I hereby certify that _____
(Name of the Insured)

of _____
(Address of the Insured)

died on the _____ day of _____, _____, from
(month) (year)

(chief or primary cause) _____

(contributing or secondary cause) _____

If death was due to suicide, specify and describe briefly _____

If death was due to illness, it began on _____
(day / month / year)

Dated at _____ this _____ day of _____.
(CITY and PROVINCE) (month) (year)

FULL NAME M.D.

SIGNATURE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Please Print Clearly)

I/We, _____, hereby authorize and direct any physician, medical practitioner, medical examiner, coroner, hospital, clinic or medically related facility, the Medical Information Bureau and any other organization, institution or person including those listed in Section A below, to provide to The Great-West Life Assurance Company/The Canada Life Assurance Company any information related to the health of and to the directly/indirectly to the death of the late _____
(Name of Insured)

PROVINCIAL HEALTH CARE NUMBER OF DECEASED _____

A photocopy of the authorization shall be as valid as the original.

DATE (day / month / year) _____

SIGN **AND** PRINT FULL NAME. _____

INDICATE ESTATE REPRESENTATIVE OR NEXT OF KIN _____

DATE (day / month / year) _____

SIGN **AND** PRINT FULL NAME. _____

INDICATE ESTATE REPRESENTATIVE OR NEXT OF KIN _____

SECTION A*

(Professional/Facility/Individual Having Medical Records/Information)

FULL NAME

COMPLETE MAILING ADDRESS AND TELEPHONE NUMBER

1. _____

Telephone # _____

2. _____

Telephone # _____

3. _____

Telephone # _____

4. _____

Telephone # _____

* If you need more space, use a separate sheet of paper and attach it to this form