Mortgage Critical Illness - Creditor Insurance Claimant Statement

Canadian Premier Life Insurance Company,
Operating under the brand name Securian Canada
Claims Department • 25 Sheppard Ave. W, Suite 1400, Toronto, ON M2N 6S6
1-877-271-8713 • Fax 1-866-748-8486 • creditor.claims@securiancanada.ca

How to submit your form(s)

You can start your claim and send in your claim forms using our Creditor Insurance Digital Claims Portal by simply visiting us at **dcp.securiancanada.ca/en**.

Note: All the forms are available on the portal. You can print or email to get them completed by the appropriate party. Once completed, you can upload the forms to the portal and submit them or use any of the other submission methods below.

You can send in your claim forms directly to Securian Canada by email *creditor.claims@securiancanada.ca*. Please be advised that although Securian Canada uses reasonable means to protect the security and confidentiality of the email content it sends and receives, the privacy or security of email communications cannot be guaranteed.

You can fax your completed claim forms to the number that appears below. If you are unable to fax this information, you can mail it to the appropriate address.

Fax: 1-866-748-8486

Securian Canada
25 Sheppard Ave. West, Suite 1400
Toronto, ON M2N 6S6

For questions about your claim, you may call Securian Canada.

Phone: 1-877-271-8713

Policy 57904

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

Start your claim via the Creditor Insurance Digital Claims Portal. Two (2) forms are required to begin the claim process:

- Claimant's Statement - You complete this form. Please be sure to sign and date it.
- Attending Physician's Statement - Ask your doctor to complete this form.

Note: The forms are available on the Portal. For the Attending Physician's Statement, you can print or email the form to your Physician.

Once completed, your physician can return the form for you to upload to the portal, fax the form to 1-866-748-8486 or email it to creditor.claims@securiancanada.ca. Securian Canada will work directly with BMO to obtain your proof of insurance materials.

Prefer not to submit online?
Visit your local BMO Branch for assistance with the required forms.

Securian Canada is the insurer and is committed to keeping your information confidential.

Claimant Information

Legal name of insured (first, middle, last)	Date of birth (dd/mm/yyyy)

Address (street, city, province, postal code)

Home telephone number	Alternative telephone number

Branch transit	Mortgage number	Current mortgage payment
		$

Payment frequency

☐ Monthly ☐ Weekly ☐ Twice monthly ☐ Every two weeks

See Reverse Side

Please attach a copy of your **application for insurance**. This was provided to you by the bank branch when you applied for the insurance.

Email address	I prefer to receive communication from Securian Canada via email ☐ Yes ☐ No

Other Insurance Policies with Securian Canada

☐ I don't have any other insurance policies with Securian Canada (skip to next section)

Contract number	Member ID	Company name
Contact person	Contact person email	Contact person telephone number

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 medical practitioner in connection with your illness? (dd/mm/yyyy)

Legal name of physician (first, middle, last)

Address (street, city, province, postal code)

Have you undergone any tests or investigations related to the diagnosis?

☐ Yes ☐ No If yes, please provide details and dates:

Have you previously suffered from, or received treatment for, a similar or related condition?

☐ Yes ☐ No If yes, please provide details and dates:

Medical Consultations

Please provide the name and address of your personal physician.

Legal name of physician (first, middle, last)	Specialty

Address (street, city, province, postal code)

How long has this physician been involved in your care?

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

Legal name of doctor/specialist (first, middle, last)	Specialty
Address (street, city, province, postal code)	Date seen (dd/mm/yyyy)
Legal name of doctor/specialist (first, middle, last)	Specialty
Address (street, 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)

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

Legal name of other physician (first, middle, last)		Specialty
Address (street, city, province, postal code)	**Telephone**	**Fax**
Legal name of other physician (first, middle, last)		**Specialty**
Address (street, city, province, postal code)	**Telephone**	**Fax**

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

First type of treatment	Date (dd/mm/yyyy)
Institution/prescribing physician	
First type of treatment	**Date (dd/mm/yyyy)**
Institution/prescribing physician	

General

Have any of your immediate family (mother, father, brothers, sisters) had cancer, tumor, heart disease, diabetes, or kidney disease prior to age 60?

☐ Yes ☐ No If yes, please provide details below.

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 Securian Canada or with another company?

☐ Yes ☐ No If yes, please complete the following.

Name of insurer	Policy number

Amount of benefit insured	Have you undergone any tests or investigations related to the diagnosis?
$	☐ Yes ☐ No

Are you currently receiving, or have you applied for short and long-term disability benefits with Securian Canada?

☐ Yes ☐ No If yes, please complete the following.

Policy number	Certificate number	Legal name of case manager (first, middle, last)

Do you smoke or use tobacco products?

☐ Yes ☐ No If yes, how long have you used tobacco? Amount per day:

If no, did you previously use tobacco products?

☐ Yes ☐ No If yes, when did you quit? (dd/mm/yyyy)

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

****See Reverse Side****

Contact Authorization

You may contact someone else to communicate with us regarding the claim on your behalf. If you would like to authorize someone else, provide the details below.

Legal name (first, middle, last)	Relationship to claimant
Address (street, city, province, postal code)	Telephone number

Your Permission

Please fill out and sign:

- **The Claimant's Critical Illness Statement (this form)**

I agree that the statements in this form are true and complete.

Reference to Securian Canada or Bank of Montreal includes their agents and services providers.

I allow Securian Canada, Bank of Montreal and it's re-insurers to collect, use and disclose:

- Information needed to process my critical illness claim
- Relevant information with health professionals, institutions, investigative agencies, insurers and, where appropriate, Bank of Montreal, to underwrite, administer and adjudicate my claims

I allow Securian Canada and Bank of Montreal to collect, use and disclose:

- Financial information related to my claim needed to administer the claim
- Relevant claims information – including details about my diagnosis and treatment when dealing with re-insurers only

Conditions of consent

- My consent is valid for the duration of my claim
- If Bank of Montreal is audited, my claim may become part of the audit
- My consent is valid for the duration of the audit

Overpayment

If Securian Canada overpays me, I allow them to:

- Recover the money from any amount payable to me under my creditor benefits plan(s).

Preventing fraud and abuse

If Securian Canada suspects fraud or abuse, Securian Canada can investigate my claim. To detect, investigate and prevent fraud and abuse, Securian Canada can collect, use and disclose information about my claim with relevant organizations. These include Bank of Montreal, regulatory bodies, government organizations and other insurers.

A photocopy or electronic version of this form is as valid as the original.

Claimant's legal name (please print)

Claimant's signature **X**	Date signed (dd/mm/yyyy)

Respecting your privacy

Respecting your privacy is a priority for Securian Canada. We keep in confidence personal information about you and the product and the services you have with us to provide 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; and meeting legal, regulatory or contractual requirements; and we may tell 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. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. 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, you may contact our Privacy Office at: 1-888-968-4155, by mail at: Privacy Office, 25 Sheppard Avenue West, Suite 1400, Toronto, ON M2N 6S6, or visit http://www.securiancanada.ca/privacy-statement.

Mortgage Critical Illness - Creditor Insurance
Attending Physician's Statement - Cancer Statement

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

- Please do not include the results of any genetic testing performed on your patient.
- Please return this form to your patient once it is completed.
- 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.

Patient Information

Legal name of patient (first, middle, last)	Date of birth (dd/mm/yyyy)
Address (street, city, province, postal code)	Telephone number

Physician Information

Your patient would appreciate completion of this form as soon as possible otherwise there may be delays in processing this claim.

When did your patient first have symptoms? (dd/mm/yyyy)

Please provide the exact diagnosis and nature of the cancer

What were the symptoms?

When did your patient first consult you for this condition? (dd/mm/yyyy)	How long has this person been your patient?

Please provide the date this cancer was diagnosed (dd/mm/yyyy)

When was the patient advised of the diagnosis? (dd/mm/yyyy)	Advised by whom?

Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this cancer

Please provide a copy of the pathology report giving the following details:

Type of tumour

Site of tumour

Histology and staging

Has your patient previously suffered from cancer or any predisposing disorders? If so, please provide dates and details.

Has your patient ever been tested for the Human Immunodeficiency Virus?

☐ Yes ☐ No If yes, date (dd/mm/yyyy): Result:

Is there a family history of cancer?

☐ Yes ☐ No If yes, please provide details.

Please provide details of any other significant family history

Please provide details of your patient's tobacco use, including amount per day and date last used

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

Please provide copies of all test results, pathology reports, surgical reports and consultation reports with respect to this condition.

Attending Physician's Signature

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

Physician's legal name (first, middle, last)	Degree	
Address (street, city, province, postal code)	Telephone number	Fax number
Physician's signature **X**	Date signed (dd/mm/yyyy)	