Mortgage Critical Illness - Creditor Insurance
Bank 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@canadianpremier.ca

Policy 57904

Attention Banker - This form to be completed by the branch representative.

Instructions:

If the balance protection indicator in the *Inquiry: Mortgage at a Glance* is "none/no" and the coverage status for critical illness coverage in the *Inquiry: Creditor Insurance at a Glance* is either "waived," "quote" or "ineligible," advise the customer there is no critical illness coverage in force and do not provide a claim package.

☐ **Attach a copy of all insurance applications pertaining to this claim.**
If the insurance enrolment originated from the Customer Contact Centre, there will not be a copy of the original signed application. To determine if an enrolment occurred through the Customer Contact Centre, you can check Optimizer for closed service requests. Please indicate in the text box below if this is the case and include the service request number from Optimizer where available.

If the copy of the original application(s) is/are not attached, please explain why:

☐ **Attach print screens of *Inquiry: Creditor Insurance at a Glance* (only if insured customer's coverage status for critical illness is "active").**
Press "**Windows key + shift + s**". Your screen will appear grayed out and your mouse cursor will change. Click and drag on your screen to select the inquiry screens requested. A screenshot of the screen region you selected will be copied to your clipboard. Open a new Word document and **paste**. If the completed claims forms are being emailed, **save** so the attachment can be **attached**. If the completed claims forms are being faxed, please **print**.

How to submit this form, print screens and original applications:

- Please provide this completed form, the required **print screens** and copies of **all original applications** to your customer with the claims package.
- If your customer requests, you can send this form, **print screens** and **original applications** directly to Canadian Premier by email to creditor.claims@canadianpremier.ca or fax the documents to 1-866-748-8486. If you fax or email the form, you can keep the original copy for your records.

Customer Information

Legal name of insured (first, middle, last)

Mortgage Information

☐ **Attach print screens of** *Inquiry: Mortgage at a Glance*

Mortgage number	Effective date of insurance (dd/mm/yyyy) (only if insured customer's coverage status for critical illness is "active" on the *Inquiry: Creditor Insurance at a Glance*

Funding mortgage account number

Institution number: Transit number: Account number:

Banker Information

Banker's legal name (first, middle, last)	Branch transit number	Current date (dd/mm/yyyy)
Address (street, city, province, postal code)		Telephone number

☐ Copies of all **insurance applications** are attached

☐ All required **print screens** are attached

☐ **Critical illness coverage is "active" on the *Creditor Insurance at a Glance***

See Reverse Side

Please ensure that the application and all print screens are included in the claim submission. Note that if this information is incomplete or missing, **Canadian Premier will not be able to process the claim and additional delays will occur.**

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

I also certify that the above documents are attached (where applicable).

Signature of banker	Title	Date signed (dd/mm/yyyy)
X		

Mortgage Critical Illness - Creditor Insurance Claimant Statement

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

There are three (3) forms that are required to begin the claim process:

- Claimant's Statement - This form is for you to complete. Please be sure to sign and date the form.
- Attending Physician's Statement - Please give this form to your medical practitioner to complete.
- Bank Statement.

Your local BMO branch representative must:

- ☐ Complete the Bank Statement
- ☐ Provide **print screen** with details of your creditor insurance coverage
- ☐ Provide copies of your **application(s) for creditor insurance**

Canadian Premier Life Insurance Company (Canadian Premier) 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

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 Canadian Premier via email
	☐ Yes ☐ No

Other Insurance Policies with Canadian Premier

☐ I don't have any other insurance policies with Canadian Premier (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

See Reverse Side

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
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Are you insured for individual critical illness benefits with Canadian Premier 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 Canadian Premier?

☐ 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

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 Canadian Premier or Bank of Montreal includes their agents and services providers.

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

- Information needed to process my Mortgage 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 Canadian Premier 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

See Reverse Side

Overpayment

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

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

Claimant's legal name (please print)

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

How to submit your completed form(s)

You have multiple ways of submitting your completed claim forms to us, along with any other information in support of your claim. For all options, except for mail, you can keep the original copies for your records.

You can send in your claim forms directly to Canadian Premier by email *creditor.claims@canadianpremier.ca*. Please be advised that although Canadian Premier 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

Canadian Premier Life Insurance Company
25 Sheppard Ave. West, Suite 1400
Toronto, ON M2N 6S6

For questions about your claim, you may call Canadian Premier.
Phone: 1-877-271-8713

Respecting your privacy

Respecting your privacy is a priority for Canadian Premier Life Insurance Company. We keep in confidence personal Respecting your privacy is a priority for Canadian Premier Life Insurance Company. We collect information from application forms and other information you provide to us or our distribution partners in connection with insurance and/or financial products offered by us, as well as (with your consent) through independent medical or vocational assessments, if applicable, and from physicians, medical practitioners, hospitals, clinics or other medical or medically related facilities, insurance companies, MIB, LLC ("MIB"), and other agents, government agencies or other organizations, institutions, or persons that have health records, if applicable. We collect, use and disclose your personal information for purposes that include: confirming your identity, underwriting, including determining your eligibility or need for insurance and/or financial products you request; administration and servicing; claims adjudication; protecting against fraud, errors or misrepresentations; and meeting legal, regulatory or contractual requirements. We will give access to your personal information only to those of our employees and independent contractors, affiliates within our corporate group, administrators, distribution partners, and other third-party service providers and outsourcers, along with our reinsurers, who need your personal information to do their jobs. We will also provide access to anyone else you authorize. All of our service providers with whom we have a contractual relationship are required to protect your personal information in accordance with this privacy statement and our privacy practices. Sometimes, unless we are otherwise prohibited, these people may be in, or your personal information may be stored on servers located in, other provinces in Canada or in countries outside Canada, so your personal information may be subject to the laws of those other provinces or 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, visit http://www.canadianpremier.ca/privacy-statement.

Mortgage Critical Illness - Creditor Insurance
Attending Physician's Statement -
Stroke Cerebrovascular Accident (CVA) 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 consult you for this condition? (dd/mm/yyyy)	How long has the insured been your patient?
Was a diagnosis of Cerebrovascular Accident (CVA) made? ☐ Yes ☐ No	When did the CVA occur? (dd/mm/yyyy)

Please describe the cause of the CVA

Please describe the measurable residual neurological deficits

How long have the neurological deficits persisted?	By whom was the diagnosis made?
When was the patient advised of the diagnosis? (dd/mm/yyyy)	Advised by whom?

Please provide a copy of the CT scan or MRI if available.

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

What other investigations have been performed? Please provide dates and details, or reports.

See Reverse Side

When did your patient first suffer symptoms or episodes of cerebrovascular disease? (dd/mm/yyyy)

What were they?

Please describe (including dates) any predisposing disorders or risk factors that your patient had for cerebrovascular disease

Is there a family history of cardiovascular disease or cerebrovascular disease?

☐ Yes ☐ No If yes, please provide details.

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

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)	