BMO Bank of Montreal

When printed at BMO branch:

BMO employee must follow the steps below:

1. Before your customer leaves the branch:
   - Complete the Bank Statement found in this claim package on pages 2 & 3.
   - Provide your customer with a copy of their Insurance Application Form found in their customer file.
     Note: You may need to request a copy from their home branch.
2. Advise your customer to carefully read and follow the instructions on page 1 of this claim package to complete their claim.

When printing at home:

BMO client must follow the steps below:

1. This claim package includes:
   - **Bank Statement:** Bring to your local branch to complete this statement. While you are at your branch, collect a copy of the Insurance Application Form.

     To locate your nearest branch and book an appointment visit branchlocator.bmo.com.
   - **Claimant Statement:** To be completed by the claimant.
   - **Attending Physicians Statement:** To be completed by the treating doctor.
2. Carefully read and follow the instructions on page 1 for additional required documentation.
3. Once all of the above are completed and in your possession, submit them to Sun Life as per the instructions on page 1 of this claim package.

Important notes:

- Sun Life will only process your claim when **all** statements are fully completed.
- For questions about your claim, you may call Sun Life Assurance Company of Canada at 1-877-271-8713.
- Discard this page before sending to Sun Life.

BMO Bank of Montreal

Mortgage 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) – –	

Branch Domicile Stamp

What information is required for a Critical Illness claim?

Checklist:

- ☐ a completed Bank Statement
- ☐ a completed and signed Claimant Statement
- ☐ a completed and signed Attending Physician's Statement*
- ☐ a copy of the Mortgage Insurance Application(s) pertaining to this claim.

* 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.

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

Please return your completed claim package in a sealed envelope except for the Bank's Statement to your Branch. The Bank will submit your claim forms to Sun Life on your behalf.

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 medical practitioner 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 mortgage payments in full.
- For questions about your claim, you may call Sun Life Assurance Company of Canada at 1-877-271-8713.

Sun Life Assurance Company of Canada is the insurer, and is a member of the Sun Life Financial group of companies.

BMO Bank of Montreal

Sun Life Financial

Mortgage Critical Illness Insurance Claim

Creditor Insurance – Policy no. 57904

Bank's Statement

Instructions

- Sections 1, 2, 3 and 4 to be completed by the Bank of Montreal Branch
- Attach a copy of the Mortgage Insurance Application(s) pertaining to this claim
- Give the entire claim package to the customer to complete
- Advise the customer to return the claim package in a sealed envelope (except for the Banks's Statement) to the Branch
- Send the completed claim package in a sealed envelope along with the Bank's Statement to the Mortgage Service Centre (MSC) for completion of Section 5 and 6

1 Insured's information

First name	Last name	☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr.	Language ☐ English ☐ French
Date of birth (dd-mm-yyyy)	Date of diagnosis (dd-mm-yyyy)	Telephone number	
Address (street number and name)			Apartment or suite
City	Province		Postal code

2 Mortgage information

Mortgage number	Effective date of insurance (dd-mm-yyyy)

Is this mortgage ☐ New ☐ Refinanced – If refinanced, was it previously insured? ☐ Yes ☐ No
☐ Pre-approved mortgage – If *yes*, what is the closing date (dd-mm-yyyy)

Authorized amount	Current premium payments at date of Critical Illness			
$	Disability $	Life $	Critical Illness $	Job loss $
	☐ Monthly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly	☐ Monthly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly	☐ Monthly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly	☐ Monthly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly

Current balance	Percent of balance covered	Coverage status
$	☐ 50% ☐ 100% ☐ Other	☐ Active ☐ Ineligible ☐ Approved ☐ Waived ☐ Pending

3 Insured co-borrower

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

4 Lender information

First name	Last name	
Telephone number	Transit number	Current date (dd-mm-yyyy)

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

Signature of lender	Title
X	

5 Mortgage information – to be completed by the Bank of Montreal Mortgage Service Centre

Calculation of Amount Owing on (date of diagnosis) $ (if Mortgage was partially advanced at the date of diagnosis insert amount of approved Mortgage)	
Principal outstanding	$
Unpaid Interest	$
Principal and unpaid interest owing	$
Amount of debit of tax account	$
Accrued debit interest on tax account	$
Amount owing as of date of diagnosis	$
Bonus payable	$
Discharge fee	$
Total amount owing as at date of diagnosis	$
Total per diem on outstanding amount advanced before date of diagnosis	$

6 Bank of Montreal Mortgage Service Centre Representative

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

Date (dd-mm-yyyy)	Authorized signer	Title
– –		

Address (street number and name)	Telephone number
	– –

City	Province	Postal code

BMO Bank of Montreal

Mortgage Critical Illness Insurance Claim
Creditor Insurance – Policy no. 57904

Sun Life Financial

Claimant's Statement

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

Instructions

- The "Claimant's Statement" must be fully completed, making sure all questions are answered.
- Please be sure to indicate your mortgage number below.
- Please be sure to sign and date the Claimant Authorization.
- Print clearly in block letters.
- Please return your completed claim package in a sealed envelope except for the Bank's Statement to your Branch.

1 Claimant information

First name				Last name		
Address (street number and name)						
City				Province	Postal code	
Date of birth (dd-mm-yyyy) – –	☐ Male ☐ Female	Language	☐ English ☐ French	Telephone number – –		☐ Bus. ☐ Res.
Mortgage 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 medical practitioner in connection with your illness? (dd-mm-yyyy) – –

Physician's first name		Last name	
Physician's address (street number and name)			Apartment or suite
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)		Apartment or suite
City	Province	Postal code

How long has this physician been involved in your care?

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

First name	Last name		Specialty
Address (street number and name)			Apartment or suite
City	Province	Postal code	Date seen (dd-mm-yyyy)

First name	Last name		Specialty
Address (street number and name)			Apartment or suite
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.

First name		Last name		Specialty
Address (street number and name)				Apartment or suite
City	Province	Postal code	Telephone number	Fax number

3 Medical consultations (continued)

First name	Last name	Specialty

Address (street number and name)	Apartment or suite

City	Province	Postal code	Telephone number	Fax
			– –	– –

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) – –

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
Amount of benefit insured $	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

Do you smoke or use tobacco products? ☐ **Yes** ☐ **No** **If *yes*, please indicate:**

Amount per day	How long have you used tobacco?	If *no*, did you previously use tobacco products? ☐ Yes ☐ No	When did you quit? (dd-mm-yyyy) – –

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 authorized 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 administration of the plan.

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 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, visit *www.sunlife.ca/privacy*.

BMO Bank of Montreal

Mortgage Critical Illness Insurance Claim
Creditor Insurance – Policy no. 57904

Sun Life Financial

Attending Physician's Statement – Stroke Cerebrovascular Accident (CVA) Statement

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

Instructions

- Please do not include the results of any genetic testing performed on your patient.
- 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 suite
City	Province	Postal code	Telephone number

2 Physician information

Your patient would appreciate completion of this form as soon as possible otherwise there maybe 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.

2 Physician information (continued)

Please give 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.

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	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.

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	Degree
Address (street number and name)		Apartment or suite
City	Province	Postal code
Telephone number — —	Fax number — —	
Physician's signature X		Date (dd-mm-yyyy) — —