Mortgage Disability - 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 51007

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

Instructions:

If the disability/payment protection indicator in the *Inquiry: Mortgage - At a Glance* is "none/no" and the coverage status for disability coverage in the *Inquiry: Creditor Insurance at a Glance* is either "waived," "quote" or "ineligible," advise the authorized representative there is no disability 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 disability 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 disability 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

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

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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		

By furnishing this form or any other form, the Company does not admit that any coverage is in force nor waive any of its rights or defenses.

Mortgage Disability - Creditor Insurance Claimant Statement

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Proof of claim must be submitted within 120 days of the date of disability.

There are four (4) 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.
- Employer's Statement - Please have your employer complete this form.
- Bank Statement

Your local BMO branch representative must:

☐ Complete the Bank Statement;
☐ Provide **print screen** with details of your creditor insurance coverage; and
☐ 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

Claimant's legal name (first, middle, last)	Date of birth (dd/mm/yyyy)

Address (street, city, province, postal code)

Home telephone number	Alternate 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

About your Illness or Injury

Please describe your present illness or injury and how it occurred

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

Have you ever had the same or similar illness or injury?

☐ Yes ☐ No If yes, please explain and give dates:

See Reverse Side

Is your condition related to pregnancy?

☐ Yes ☐ No If yes, what is your delivery date? (dd/mm/yyyy)

Please describe your complications, if any

From what date did your illness or injury prevent you from working? (dd/mm/yyyy)

Please include a list of the duties of your job that you are unable to do

What treatments are you presently receiving (medications, physiotherapy, psychotherapy, etc.)?

List all doctors you have seen for this illness or injury and any doctors you plan to see in the near future about this illness or injury.

Doctor	Address	Date of visit (dd/mm/yyyy)

Please include copies of any physician reports, specialist reports, test results or investigations you have had done. If you have had any genetic testing completed, please do not include this information as it is not required for our assessment of disability.

When do you expect to be able to return to work? (dd/mm/yyyy)

☐ Full time ☐ Part time

Have you tried to return to work already?

☐ Yes ☐ No If yes, please answer the following questions.

What were the dates that you returned to work?

From (dd/mm/yyyy): To (dd/mm/yyyy):

Did you return to?	Did you return to?
☐ Your own job ☐ New job or modified duties	☐ Full time ☐ Part time

You must notify Canadian Premier if:

- Your medical condition improves so that you are able to work part time or full time.
- You begin working again either as an employee or as a self-employed person.

Disability as a Result of an Accident

Is your disability the result of an accident?

☐ Yes ☐ No If yes, what was the date, time and location of the accident? If no, continue to the Contact Authorization section.

Date (dd/mm/yyyy)	Time	Location

Were you working for your employer at the time of the accident?

☐ Yes ☐ No Please describe how your illness or injury occurred.

Is your illness or injury due to a motor vehicle accident?

☐ Yes ☐ No If yes, please enclose a copy of the accident report.

Name of insurance adjuster

Auto carrier	Contract/policy number	Telephone number

If your disability is the result of an accident, are you taking legal action against any other person or organization?

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

Name of lawyer	Telephone number

Address (street, city, province, postal code)

On what date did the legal action start? (dd/mm/yyyy)

If no, explain why you are not taking legal action

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 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 Disability 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

Overpayment

If Canadian Premier overpays me:

- Recover the money from any amount payable to me under my creditor benefits.

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 legal name (please print)

Signature of claimant **X**	Date signed (dd/mm/yyyy)

****See Reverse Side****

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 disability 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 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.

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Employer Statement

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Proof of claim must be submitted within 120 days of the date of disability. To be completed by claimant if self-employed.

Employee Information

Employee's legal name (first, middle, last)

Address (street, city, province, postal code)

Employee's commencement date of employment (dd/mm/yyyy)	Employee's last scheduled working day (dd/mm/yyyy)	Employee's last day worked (dd/mm/yyyy)

Work Details

What was the reason for discontinuing work?

☐ Vacation ☐ Lay off ☐ Leave of absence ☐ Disability ☐ Other (specify):

Date employee is expected to return to work (dd/mm/yyyy)	Date employee returned to work (dd/mm/yyyy)

If the disability is the result of an accident, have you submitted a report of this accident to WCB/WSIB?

☐ Yes ☐ No

What was the employee's occupation or assignment at the date he/she ceased work?

This position is

☐ Full time ☐ Part time ☐ Seasonal Indicate number of hours worked per week:

From what date had he/she been assigned to this position? Canadian Premier requires a copy of the employee's job description, if none is available then list all essential duties performed for the job.

Give dates and details of sick leave or lay-off during the 12 months preceding commencement of disability

If he/she changed occupations or assignments during the 12 months before ceasing work, describe the previous occupation or assignment and give the reason for change and the effective date of this change

Signature and Certification

I certify that, according to the records of this organization, the above information is correct.

Name of authorized official (please print)	Title	
Name of employer	Telephone number	Fax number

Address (street, city, province, postal code)

Signature of authorized official **X**	Date (dd/mm/yyyy)

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Mortgage Disability - Creditor Insurance
Attending Physician's Statement

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Proof of claim must be submitted within 120 days of completion of the date of disability.

Instructions:
- 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 patient's responsibility.
- The purpose of this report is to assist us in making a disability determination. In filing 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

Patient's name (first, middle, last)	Date of birth (dd/mm/yyyy)
Address (street, city, province, postal code)	Patient's telephone number

Medical Information

History

Date symptoms first appeared or accident occurred (dd/mm/yyyy) | Date patient ceased work because of incapacity (dd/mm/yyyy)

Has patient ever had same or similar condition?
☐ Yes ☐ No If yes, state when and describe.

If the condition is long-standing, how would you describe its evolution since onset?
☐ Improved ☐ Remained the same ☐ Slight deterioration ☐ Significant deterioration

Is condition due to injury or sickness arising out of patient's employment?
☐ Yes ☐ No ☐ Unknown

Is condition due to, or related to, pregnancy?
☐ Yes ☐ No If yes, please indicate date of confinement (dd/mm/yyyy):

Is the patient receiving or in need of treatment for the use of alcohol or drugs?
☐ Yes ☐ No

Is this condition due to a self-inflicted injury or attempted suicide?
☐ Yes ☐ No

Is this condition due to elective cosmetic or experimental surgery or treatment?
☐ Yes ☐ No

Diagnosis (including any complications)

Primary diagnosis

Secondary diagnosis

Subjective symptoms

Objective findings (include current X-rays, EKGs, laboratory data and any clinical findings)

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Treatment

Date of the first visit of treatment (dd/mm/yyyy)

Date of the latest visit of treatment (dd/mm/yyyy)

Frequency of visits

☐ Weekly ☐ Monthly ☐ Other (specify):

Nature of treatment (including surgery and medications prescribed, if any)

Progress

Patient has

☐ Recovered ☐ Remained unchanged ☐ Improved ☐ Retrogressed

Patient is

☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

Has patient been hospital confined?

☐ Yes ☐ No If yes, give name and address of hospital:

Beginning date of confinement (dd/mm/yyyy)

Ending date of confinement (dd/mm/yyyy)

Cardiac (if applicable)

Functional capacity (American Heart Association)

☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

Blood pressure at last visit

Systolic / Diastolic

Has patient been hospital confined?

☐ Yes ☐ No If yes, give name and address of hospital:

Beginning date of confinement (dd/mm/yyyy)

Ending date of confinement (dd/mm/yyyy)

Physical Impairment

☐ Class 1 - No limitation of functional capacity; capable of physical activity (0-10%)

☐ Class 2 - Slight limitation of functional capacity; capable of light manual activity (15-30%)

☐ Class 3 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity (35-55%)

☐ Class 4 - Marked limitation (60-70%)

☐ Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary) activity (75-100%)

Explain how the patient's physical limitations prevent him/her from performing the essential duties of his/her occupation

Do you feel the patient could return to work provided some of his/her duties could be modified?

☐ Yes ☐ No If yes, state what these would be and the date you anticipate the patient can return to modified duties.

Mental/Nervous Impairment (if applicable)

Please use DSM-IV terminology, including multi-axial assessment and general assessment of function GAF

Axis 1 (Primary)

Axis 2

Axis 3

Axis 4

Axis 5-GAF current

State at which GAF level the patient would be fit to resume full time work

Explain how the patient's psychological limitation prevent him/her performing the essential duties of his/her occupation

Do you believe the patient is competent to endorse cheques and direct the use of the proceeds thereof?

☐ Yes ☐ No

Prognosis

Is patient now totally incapacitated?

Patient's job: ☐ Yes ☐ No Any other work: ☐ Yes ☐ No

If no, when was patient able to resume work?

Patient's job (dd/mm/yyyy): Any other work (dd/mm/yyyy):

If yes, when do you expect patient will recover sufficiently to resume work?

Patient's job (dd/mm/yyyy): ☐ Indefinite ☐ Never

Any other work (dd/mm/yyyy): ☐ Indefinite ☐ Never

To assist Canadian Premier to promptly complete our assessment of the claim for disability submitted by the patient, please provide the dates the patient consulted you or any other physician for this or any other condition in the last 3 years.

Dates (mm/yyyy)	History (physical findings)	Diagnosis	Treatment

Provide us with any copies of any available test results, hospital records, consultation, and specialist reports.

Indicate the names and addresses of any other physicians who have treated this patient in the last 3 years.

Name	Specialty	Address	Telephone, Fax

Signature of Attending Physician

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

Name of physician (please print)	Degree
Address (street)	Telephone number
City, province, postal code	Fax number
Signature of physician **X**	Date signed (dd/mm/yyyy)

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