Mortgage Disability - 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 51007

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

There are three (3) forms that 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.
- Employer's Statement - Ask your employer to complete this form.

For the Attending Physician's Statement and the Employer's Statement, you can print or email the forms to your Physician and Employer.

Once you receive the completed forms from the Physician and the Employer, please upload them to the portal OR fax them to 1-866-748-8486 OR email them to creditor.claims@securiancanada.ca.

Securian Canada 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 Securian Canada via email
	☐ Yes ☐ No

****See Reverse Side****

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

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:

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 Securian Canada 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

See Reverse Side

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 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 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 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 legal name (please print)

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

Respecting your privacy

Respecting your privacy is a priority for Securian Canada. 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, Inc. ("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, 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 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)

See Reverse Side

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 Securian Canada 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)

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

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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? Securian Canada 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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