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 page 2.
   - 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.
   - **Employer Statement:** Please provide this to your manager/HR department as appropriate to complete and provide back to you.
   - **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 Disability Insurance Claim Creditor Insurance – Policy no. 51007

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 Disability Claim?

Checklist:

☐ a completed Bank Statement
☐ a completed and signed Claimant Statement
☐ a completed Employer Statement
☐ **a completed and signed Attending Physician's Statement***
☐ attach a copy of all creditor insurance applications 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. Sun Life Assurance Company of Canada evaluates the information included on the statements, determines if you are unable to work and establishes an appropriate return to work date. Our decision is based on the severity of your symptoms and your job demands.

Please submit your claim to:
Sun Life Assurance Company of Canada
Creditor Team – Disability Claims
PO Box 100 Stn C
Kitchener ON N2G 3W9

Important Notes

- Proof of claim must be submitted within 120 days of the date of disability.
- No benefits are payable during the qualifying period.
- Any costs for information to substantiate your claim is your responsibility.
- The Attending Physician's Statement must be completed by a qualified medical practitioner practising in Canada or the United States of America.
- If your medical condition improves or deteriorates, you must notify Sun Life Assurance Company of Canada immediately.
- It is your responsibility to notify Sun Life Assurance Company of Canada of your return-to-work date.
- 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.

BMO Bank of Montreal

Bank's Statement

Mortgage Disability Insurance Claim Creditor Insurance – Policy no. 51007

Sun Life Financial

Instructions

- To be completed by the Branch Representative.
- Attach a copy of all mortgage insurance applications pertaining to this claim.
- Give the entire claim package to the customer once this Bank Statement is complete.
- Advise your customer to send the completed Claim Package directly to Sun Life.

1 Insured's information

First name	Last name	☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr.	Language ☐ English ☐ French
Date of birth (dd-mm-yyyy)	Date of disability (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)
Funding Mortgage account number Bank number _____ Transit number _____ Account number _____	
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)	
Mortgage payment (PIT) at date of disability $ _____ ☐ Monthly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly	Current premium payments at date of disability Disability $ _____ ☐ Monthly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly Life $ _____ ☐ Monthly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly Critical Illness $ _____ ☐ Monthly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly Job loss $ _____ ☐ Monthly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly
Last payment due date (dd-mm-yyyy)	Percent of payment covered ☐ 50% ☐ 100% ☐ Other Coverage status ☐ 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 X	Title

BMO Bank of Montreal

Employer's Statement

Mortgage Disability Insurance Claim Creditor Insurance – Policy no. 51007

Sun Life Financial

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

1 Employee information

First name	Last name	
Employee's address (street number and name)		
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)
– –	– –	– –

2 Work details

1. What was the reason for discontinuing work? ☐ Vacation ☐ Lay-off ☐ Leave of absence ☐ Disability
   ☐ Other/Specify _____

2. Date employee is expected to return to work (dd-mm-yyyy) – – **OR** Date employee returned to work (dd-mm-yyyy) – –

3. If the disability is the result of an accident, have you submitted a report of this accident to WCB/WSIB? ☐ Yes ☐ No

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

5. Is this position ☐ full time? ☐ part-time? ☐ seasonal? Indicate number of hours worked per week _____
   If seasonal, indicate inclusive annual dates of employment: **From** Date (dd-mm-yyyy) – – **To** Date (dd-mm-yyyy) – –

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

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

8. 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.

3 Certification and signature

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 number and name)		
City	Province	Postal code
Signature of authorized official X		Date (dd-mm-yyyy) – –

BMO Bank of Montreal

Claimant's Statement

Mortgage Disability Insurance Claim Creditor Insurance – Policy no. 51007

Sun Life Financial

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

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.
- It is your responsibility to advise Sun Life Assurance Company of Canada when you return to work.
- Please complete and send back to Sun Life.

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.
Branch Transit	Mortgage number	Current mortgage payment $	Payment frequency ☐ Monthly ☐ Twice monthly ☐ Weekly ☐ Every two weeks

2 Details of disability

1. a) To your knowledge, what is the diagnosis of your illness?

b) What treatment are you receiving at present (medicine, diets, advice, physiotherapy)?

c) Describe how your condition prevents you from working and from performing the duties of your occupation.

d) On what date did the first symptoms of your illness or injury appear? Date (dd-mm-yyyy) _ _

e) Date on which you first consulted a physician for your present illness or injury. Date (dd-mm-yyyy) _ _

2. a) If disability is due to an accident, where did the accident happen? Date of accident Date (dd-mm-yyyy) _ _

☐ at home ☐ at work ☐ elsewhere (where)? _____

b) How did the accident happen?

If a motor vehicle accident, were you the operator of the vehicle? ☐ Yes ☐ No If *yes*, forward copies of the police accident report if possible.

3. From what date have you been totally and continuously disabled from performing your occupation? Date (dd-mm-yyyy) _ _

4. a) Are you now ☐ House confined? ☐ Bed confined? ☐ Hospital confined? ☐ Mobile?

b) Describe your daily activities.

2 Details of disability (continued)

4. c) Have you been involved in any remunerative activities since becoming disabled? ☐ Yes ☐ No If *yes*, please give details.

d) On what date do you expect to be able to resume active employment either full or part time? Date (dd-mm-yyyy)

5. a) Give names and addresses of all physicians who attended you during your present illness or injury.

b) Give names and addresses of all physicians who have attended you in the past 3 years and provide details.

Nature of illness/injury	Dates of visits/treatments (dd-mm-yyyy)	Treatment prescribed (medicines, diets, etc.)	Names and addresses of physicians
	– –		
	– –		
	– –		

6. List any surgery performed during the hospitalizations

Type of surgery	Date of surgery (dd-mm-yyyy)	Name of hospital	Name of surgeon
	– –		
	– –		

7. If the Attending Physician's Statement of Disability is not being sent with this claim form, is your doctor sending it directly?
☐ Yes ☐ No If *no*, please explain.

8. Please indicate the policy numbers of any group or individual insurance policies under which you are insured by Sun Life Assurance Company of Canada.

3 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	– –

4 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 Disability Insurance Claim
Creditor Insurance – Policy no. 51007

Sun Life Financial

Attending Physician's Statement

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.
- To keep your report confidential, please mail directly to:
  Sun Life Assurance Company of Canada, Creditor Team – Disability Claims, PO Box 100 Stn C, Kitchener ON N2G 3W9.
- 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 disability 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

First name	Last name	☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr.	Date of birth (dd-mm-yyyy)	Telephone number

Address (street number and name)	Apartment or suite

City	Province	Postal code

2 Medical information

1. History

a) When did symptoms first appear or accident happen? Date (dd-mm-yyyy)

b) Date patient ceased work because of incapacity: Date (dd-mm-yyyy)

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

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

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

f) Is condition due to, or related to, pregnancy? ☐ Yes ☐ No If *yes*, please indicate date of confinement. Date (dd-mm-yyyy)

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

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

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

2. Diagnosis (including any complications)

a) Primary diagnosis

Secondary diagnosis

b) Subjective symptoms

2 Medical information (continued)

c) Objective findings (include current X-rays, EKG's, laboratory data and any clinical findings)

3. Date of treatment

a) Date of first visit — Date (dd-mm-yyyy) _ _

b) Date of latest visit — Date (dd-mm-yyyy) _ _

c) Frequency: ☐ Weekly ☐ Monthly ☐ Other (specify): _____

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

5. Progress

a) Has patient: ☐ Recovered ☐ Remained unchanged ☐ Improved ☐ Retrogressed

b) Is patient: ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

c) Has patient been hospital confined? ☐ Yes ☐ No If *yes*, give name and address of hospital.

Confined from — Date (dd-mm-yyyy) _ _ through — Date (dd-mm-yyyy) _ _

6. Cardiac (if applicable)

a) Functional capacity (American Heart Association)

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

b) Blood pressure (last visit) — Systolic / Diastolic

7. 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%)

Remarks:

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

b) Do you feel the patient could return to work provided some of his/her duties could be modified. If so, state what these would be and the date you anticipate the patient can return to modified duties.

2 Medical information (continued)

8. 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	Lowest in past year

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

Remarks:

a) Explain how the patient's psychological limitations prevent him/her from performing the essential duties of his/her occupation.

b) Do you feel the patient could return to work provided some of his/her duties could be modified. If so, state what these would be and the date you anticipate the patient can return to modified duties.

9. Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof? ☐ Yes ☐ No

10. Prognosis

	Patient's job	Any other work
a) Is patient now totally incapacitated?	☐ Yes ☐ No	☐ Yes ☐ No
b) If *no*, when was patient able to resume work?	Date (dd-mm-yyyy)	Date (dd-mm-yyyy)
c) If *yes*, when do you expect patient will recover sufficiently to resume work?	Date (dd-mm-yyyy)	Date (dd-mm-yyyy)
	☐ Indefinite ☐ Never	☐ Indefinite ☐ Never

d) To assist Sun Life Assurance Company of 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

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

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

Name	Specialty	Address	Telephone, Fax

3 Attending physician's 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	Date (dd-mm-yyyy)
X	– –