Line of Credit Job Loss
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 21559

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

Instructions:

☐ **Attach a copy of all insurance applications pertaining to this claim.**

How to print screens:

☐ **Attach print screens of *Inquiry: Creditor Insurance at a Glance* (only if insured customer's coverage status for disability is "active")**

Press "**Windows ket + 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)

Revolving Line of Credit

If the disability/payment protection indicator in the *Inquiry: Account at a Glance* is "no" or "none," advise the customer there is no disability coverage in force and do not provide a claim package.

☐ **Attach print screens** of the following Customer Connect Inquiries:

- Inquiry: Year to date balances
- Inquiry: *Creditor Insurance at a Glance*
- Inquiry: *Account at a Glance*

☐ **Attach the last three months statements from Web Image Retrieval (Web IR).**

Line of credit number	Coverage start date (dd/mm/yyyy) from *Inquiry: Creditor Insurance at a Glance*
91052	

If a copy of the original application(s) are not attached, please explain why. Please indicate in the text box below if this is the case and include the service request number from Optimizer where available.

Instalment Line of Credit

If the disability/payment protection indicator in the *Inquiry: Account at a Glance* is "no" or "none," advise the customer there is no disability coverage in force and do not provide a claim package.

☐ **Attach print screens** of the following Customer Connect Inquiries:

- Inquiry: *Account at a Glance*

See Reverse Side

- In the *Inquiry: Account at a Glance*:
  - If the insurance indicator reads “Payments Protection,” attach the print screens of *Inquiry: Creditor Insurance at a Glance*
  - If the insurance indicator is “disability,” attach the print screens of Service Navigator - Insurance Maintenance - Disability Insurance tab

☐ **Attach print screens** of the following screens:
- Service navigator - Payments - Payments History/Current Amount Due

Line of credit number **91052**	Coverage start date (dd/mm/yyyy) from *Inquiry: Creditor Insurance at a Glance*

If a copy of the original application(s) are not attached, please explain why. Please indicate in the text box below if this is the case and include the service request number from Optimizer where available.

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

☐ **Job loss coverage is “active” on the *Creditor Insurance at a Glance***

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 **X**	Title	Date signed (dd/mm/yyyy)

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.

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

There are six (6) 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.
- Employer's Statement - Please have you employer complete this form.
- Record of Employment - Please provide a copy of this form.
- From the Government of Canada website, select option "My Service Canada Account" and provide PDF print screens of:
  - ☐ "My Latest Claim"; and
  - ☐ "My Payments"
- Bank Statement

Your local BMO branch representative must:

- ☐ Complete the Bank Statement; and
- ☐ 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

Account number

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

Employment Details

Occupation at date of job loss

Employment type	If seasonal, regular months of employment (dd/mm/yyyy)
☐ Full time ☐ Part time ☐ Seasonal ☐ Temporary	From: To:

Brief job description

Name of employer (at time of job loss)

Address (street, city, province, postal code)

Last day worked (dd/mm/yyyy)	Date returned to work (dd/mm/yyyy)	Expected date of return to work (dd/mm/yyyy)

See Reverse Side

Employment Details (continued)

If employed by the above employer for less than 6 months, please provide:

Name of previous employer

Address (street, city, province, postal code)

Please provide details regarding your Employment Insurance (EI) application (please include a copy of all EI correspondence for this claim).

Date you registered for EI benefits (dd/mm/yyyy)	Benefit effective date, if known (dd/mm/yyyy)

Contact Authorization

You may authorize someone else to communicate with Canadian Premier regarding this claim on your behalf. If you would like to authorize someone else, please 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 Line of Credit Job Loss 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'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 completed 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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Employee Information

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

Employee's 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)

Employment Details

Reason for discontinuing work

☐ Dismissal without cause ☐ Lay off ☐ Unionized labour dispute ☐ Strike or lockout
☐ Other (specify):

If lay off, date employee notified (dd/mm/yyyy)	Date expected to return to work (dd/mm/yyyy)	Date returned to work (dd/mm/yyyy)

Occupation as of last day worked

Type of position

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

If seasonal, provide inclusive date of employment (dd/mm/yyyy)

From: To:

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, city, province, postal code)

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

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