BMO Bank of Montreal

Line of Credit 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) – –	

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What information is required for a Critical Illness claim?

Checklist for the Claimant:

☐ a completed and signed Lender's Statement
☐ a copy of the Line of Credit Insurance Application(s) pertaining to this claim
☐ a completed and signed Claimant Statement
☐ a completed and signed Attending Physician's Statement*

* You must complete the Patient Authorization on the Attending Physician's Statement. 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.

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

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 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 Physician or Specialist 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 line of credit payments in full.
- For questions about your claim, you may call Sun Life Assurance Company of Canada at 1-877-271-8713.

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BMO Lender's Statement

Instructions – to be completed by the BMO Lender

- Give the customer the entire claim package including this Lender's Statement once it is completed.
- Provide copies of all line of credit or loan insurance applications pertaining to this claim to the customer.
- **For any Line of Credit product please also attach screen prints of the last 12 months average balances prior to the date of critical illness. Please refer to *"Inquiries – Year to date balances"* and provide a screen shot of the screen. Important: Please write the date the screen print was taken.**
- Advise your customer to send the completed claim package directly to Sun Life.
- If the coverage status on the ***"Creditor Insurance at a Glance"*** screen is **"Ineligible"** or **"Waived"** please advise the customer there is no critical illness coverage in force and do not provide a claim package.

1 Insured's information

First name	Last name	☐ Male ☐ Female	Language ☐ English ☐ French
Date of birth (dd-mm-yyyy)	Date of diagnosis (dd-mm-yyyy)	Telephone number	
Address (street number and name)		Apartment or unit number	
City	Province	Postal code	

2 Revolving Line of Credit – BMO Lenders please note that Sun Life requires all boxes in this section to be completed.

Line of Credit number
91052 _____ _____ _____

Refer to *"Loan Account Details"* screen to complete this section

Authorized limit
$

Refer to *"Inquiry – Creditor Insurance at a Glance Screen"* to complete this section

When coverage starts (dd-mm-yyyy)	Max amount covered
	$

Current balance
$

Current critical illness coverage status
☐ Active ☐ Ineligible ☐ Approved ☐ Waived ☐ Pending ☐ Terminated ☐ Cancelled ☐ Quote

3 Instalment Line of Credit – BMO Lenders please note that Sun Life requires all boxes in this section to be completed.

Line of Credit number
91052 _____ _____ _____

Refer to *"Service Navigator – Features - Renewal and Interest Rate"* screens to complete this section

Original loan amount/limit	Date opened (dd-mm-yyyy)
$	

Refer to *"Inquiry – Creditor Insurance at a Glance Screen"* to complete this section

When coverage starts (dd-mm-yyyy)	Coverage option percentage	% of critical illness payment covered
	CI _____ %	%

Current balance
$

Current critical illness coverage status
☐ Active ☐ Ineligible ☐ Approved ☐ Waived ☐ Pending ☐ Terminated ☐ Cancelled ☐ Quote

4 Insured co-borrower

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

5 Lender information

First name		Last name
Title	Transit number	Telephone number

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

Signature of BMO lender	Date signed (dd-mm-yyyy)
X	

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Claimant's Statement

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

Instructions

- Print clearly in block letters.
- The "Claimant's Statement" must be fully completed, ensuring all sections are completed.
- Please indicate your line of credit number below.
- Please sign and date the Claimant Authorization.

1 Claimant information

First name		Last name	
Date of birth (dd-mm-yyyy)	☐ Male ☐ Female	Language ☐ English ☐ French	Telephone number ☐ Bus. ☐ Res.
Address (street number and name)			Apartment or unit
City		Province	Postal code
Line of Credit 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 Physician in connection with your illness? (dd-mm-yyyy)

Physician's first name	Last name	
Physician's address (street number and name)		Suite or unit
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)	Telephone number	Suite or unit
City	Province	Postal code

How long has this physician been involved in your care?

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

First name	Last name	Specialty
Address (street number and name)	Telephone number	Suite or unit
City	Province / Postal code	Date of first visit (dd-mm-yyyy)

First name	Last name	Specialty
Address (street number and name)	Telephone number	Suite or unit
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)

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)

3 Medical consultations (continued)

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)	Suite or unit

City	Province	Postal code	Telephone number
			– –

First name	Last name	Specialty

Address (street number and name)	Suite or unit

City	Province	Postal code	Telephone number	Fax
			– –	– –

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	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

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 authorize 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. A photocopy of this authorization is as valid as the original and shall continue to have effect throughout the duration of the claim.

Signature of claimant	Date (dd-mm-yyyy)
X	– –

6 Keeping your information confidential

We are responsible for all personal information in our possession, including information transferred to a third-party service provider or agent, so that we can provide you with a product or service. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. All such persons, whether or not they are located in Canada, are required to protect the confidentiality of your personal information in a manner that is consistent with our privacy policy and practices.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by email to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

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Attending Physician's Statement – Coronary Artery Bypass Surgery Statement

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

Instructions

- 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 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 (This section must be completed, signed and dated by the patient before the physician completes part 3 below.)

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 unit
City	Province	Postal code
Telephone number		
– –		

2 Patient's authorization and signature

I authorize my physician to collect, use and disclose information with Sun Life Assurance Company of Canada, its agents, service providers and reinsurers for the purposes of underwriting, administration and adjudicating my claim under this insurance plan. I agree that a photocopy or electronic version of this authorization is as valid as the original and shall continue to have effect throughout the duration of my claim.

Patient's signature	Date (dd-mm-yyyy)
X	– –

3 Physician information

Please fully complete all sections of this form. Please attach all available test results and consultation reports relevant to your patient's condition. It is your patient's responsibility for all costs in completing these forms.

When did your patient first suffer symptoms or episodes of cardiovascular disease? (dd-mm-yyyy)	
– –	
What were the symptoms?	
When did your patient first consult you for these symptoms? (dd-mm-yyyy)	How long has this person been your patient?
– –	
Please provide the pre-operative angiography findings or a copy of the report	
Please give details of the bypass surgery and surgical report, if available	
Date of surgery (dd-mm-yyyy)	Which arteries were bypassed?
– –	
Name and address of hospital	

3 Physician information (continued)

Name of cardiovascular surgeon, if other than yourself	Last name	
Address (street number and name)		Suite or unit
City	Province	Postal code

Please describe (including dates) any predisposing conditions or risk factors that your patient has had for cardiovascular disease.

Please give the names and addresses of other physicians consulted or hospitals attended by your patient for this or any related condition.

Is there a family history of cardiovascular disease or cerebrovascular disease? ☐ Yes ☐ No	Please provide details

Please provide any other information that would be helpful in the assessment of your patient's claim.

Please provide copies of test results (such as a copy of the pre-approved Coronary Angiography findings, the Coronary Artery Bypass operative report, discharge summaries, etc) and a copy of all consultation reports with respect to this condition.

4 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	Speciality
Address (street number and name)		Suite or unit
City	Province	Postal code
Telephone number – –	Fax number – –	
Physician's signature X		Date (dd-mm-yyyy) – –