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<br>X | |
| Telephone number<br>– – | Fax number<br>– – |
| Date (dd-mm-yyyy)<br>– – | |

Branch Domicile Stamp

**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.

BMO Bank of Montreal

# Line of Credit Critical Illness Insurance Claim Creditor Insurance – Policy no. 57904

Sun Life Financial

## 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 | |

BMO Bank of Montreal

# Line of Credit Critical Illness Insurance Claim Creditor Insurance – Policy no. 57904

Sun Life Financial

## 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) | | | Suite 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.

BMO Bank of Montreal

# Line of Credit Critical Illness Insurance Claim
# Creditor Insurance – Policy no. 57904

Sun Life Financial

## Attending Physician's Statement – Heart Attack (Myocardial Infarction) 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.**

| How long has this person been your patient? | When did your patient first consult you for this condition (dd-mm-yyyy) |
|---|---|
| | – – |
| Was a diagnosis of MI made?<br>☐ Yes ☐ No | If Yes, date of diagnosis (dd-mm-yyyy)<br>– – |
| Provide the name of the cardiologist who made the diagnosis of MI, if other than you: | |
| Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this MI. | |
| Please provide description of onset of chest pain pertaining to the insured's MI. | Date of onset occurred (dd-mm-yyyy)<br>– – |
| Please provide ECG changes in detail at time of event.* | |

## 3 Physician information (continued)

| |
|---|
| Please provide cardiac enzyme levels and/or troponin including CK – MB fraction and percentage of total CK at time of diagnosis pertaining to the insured's MI. |
| What other investigations have been performed? Please provide dates and details, or reports. |

***Provide copies of tracings pertaining to the insured's myocardial infarction, if available.**

| |
|---|
| When did your patient first suffer symptoms or episodes of cardiovascular disease? Please provide details and dates (dd-mm-yyyy) |
| Please describe including dates, symptoms and any predisposing conditions or risk factors that your patient has had for cardiovascular disease. |
| Is there a family history of cardiovascular disease or cerebrovascular disease? ☐ Yes ☐ No<br>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 and consultation reports with repect to this condition, including a copy of the following:

A) The ECG's that document this myocardial infraction

B) The cardiac enzyme level reports, including CK-MB BANS, Troponin I or Troponin T documenting this myocardial infraction

C) All ECG test results, cardiac enzyme test and consultation and discharge notes

D) Reports of any other cardiac investigation performed such as coronary angiography, echocardiography, etc.

## 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<br>X | | Date (dd-mm-yyyy) |