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Creditor Insurance Claim Form

Instructions for Life Claim

What information is required for a Life Claim?

- Completion of the creditor life insurance claim form and other supporting evidence as requested

Instructions for Disability Claim

What information is required for a Disability Claim?

- Completion of the creditor disability or job loss claim form with the following sections completed:
  - Claimant Statement
  - Employer Statement
  - Attending Physician Statement

Instructions for Job Loss Claim

What information is required for a Job Loss Claim?

- A copy of your Record of Employment filed with Human Resources Development Canada, **and**
- Completion of the creditor disability or job loss claim form with the following sections completed:
  - Claimant Statement
  - Employer Statement

What happens after a Claim is submitted?

- You will be advised if further information is required to process your claim.
- You are responsible for any payments until the claim is approved. If the claim is approved, the Insurer will pay disability and job loss benefits after the 30 day wait period.
- On approval of your claim, a notice will be sent to you indicating the payment(s) made on your behalf.
- If your claim is denied, the Insurer will advise you in writing.

Do you need more information?

- Refer to your certificate of creditor insurance for information about the benefits, exclusions, limitations and termination of benefits.
- **Call the Creditor Insurance Helpline at 1-800-465-6020**

Where to send claim(s)

Sun Life Assurance Company of Canada
c/o Creditor Insurance Customer Service
P.O. Box 3020, Mississauga STN A
Mississauga, ON L5A 4M2

Creditor insurance is underwritten by Sun Life Assurance Company of Canada and administered by Canadian Imperial Bank of Commerce.

Claimant information

☐ Mr. ☐ Mrs. First Name

☐ Ms ☐ Miss Last Name Date of Birth (DD/MM/YYYY)

Mailing Address

Number Street

City Province select Postal Code Telephone Number

Occupation at date of disability/job loss

Preferred correspondence language ☐ English ☐ French

Self-employed ☐ Yes ☐ No Employment type ☐ Full-time ☐ Part-time ☐ Seasonal ☐ Temporary

If seasonal, regular months of employment (day, month, year) From To

Brief job description Telephone Number

Name and address of employer (at time of disability/job loss)

Last day worked (day, month, year) Date returned to work (day, month, year) Expected date of return to work (day, month, year)

If employed by above employer less than 12 months, please provide:

Name and address of employer Telephone Number

Frist day worked (day, month, year) Last day worked (day, month, year)

Are you currently receiving or will you become entitled to receive any benefits by reason of your disability or job loss from any of the following?

☐ Workers' Compensation Board and Reference No.

☐ E.I. (provide date you registered for E.I. benefits)

☐ Canada or Quebec Pension Plan

☐ Any other group coverage (provide company name and policy number)

☐ Individual insurance coverage (provide company name and policy no.)

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Creditor Disability or Job Loss Claim
Claimant Statement

Complete if submitting a disability claim

Cause of disability ☐ Sickness ☐ Accident

If accident, provide date of accident (day, month, year)

Location of accident ☐ Work ☐ Elsewhere (specify)

How did accident happen/cause of disability

If MVA, include police report

Date illness began (day, month, year)

Nature of illness or injury

Present treatment (medication, diets, physiotherapy, etc.)

Have you been hospitalized for this condition? ☐ No ☐ Yes, name of hospital

Dates hospitalized (day, month, year) From To

Have you ever had same or similar condition? ☐ No ☐ Yes, state when and describe:

Names and addresses of all physicians consulted for present condition within the last year

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 to collect, use and exchange information about me (including psychologically related conditions and HIV/AIDS related conditions)needed for underwriting, administration and adjudicating claims and Canadian Imperial Bank of Commerce ("CIBC") for the purpose of administering my claim, 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 my claim.

Date (DD/MM/YYYY) | Name | X Signature

Please submit to:

Sun Life Assurance Company of Canada
c/o Creditor Insurance Customer Service
P.O. Box 3020, Mississauga STN A
Mississauga, ON L5A 4M2

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Employer Information

To be completed by the Employer for whom you were working at commencement of disability/unemployment.

If unemployed at your date of disability, to be completed by Employer for whom you last worked. If self-employed, to be completed by Claimant.

Name of Employer

Name of Claimant

Mailing Address

Number Street

City Province select Postal Code

Commencement date of employment (day, month, year)

Date last worked (day, month, year)

Reason for discontinuing work

If layoff, date employee notified (day, month, year)

Date expected to return to work ☐ Full-time ☐ Part-time (day, month, year)

OR Date returned to work ☐ Full-time ☐ Part-time (day, month, year)

Did employee receive severance? ☐ No ☐ Yes, date severance ends (day, month, year)

Occupation as of last day worked

Type of position

☐ Full-time specify number of hours worked per week

☐ Part-time specify number of hours worked per week

Seasonal, provide inclusive dates of employment: (day, month, year) From To

For disability claims only - Brief outline of job duties and physical requirements (e.g.: amount of standing, bending, lifting, sitting, etc.) Please forward copy of job description.

Has a claim been submitted to WCB? ☐ No ☐ Yes, indicate the office address

Name of insurance company (other than Worker's Compensation) providing group disability coverage for your employees. Please include Policy Number and contact person.

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Creditor Disability or Job Loss Claim
Employer Statement

I certify that according to the records of this organization the above information is correct.

Name of authorized officer
(please print)

Title

Telephone Number

Date (dd/mm/yyyy)

Name

X

Signature

Please submit to:

Sun Life Assurance Company of Canada
c/o Creditor Insurance Customer Service
P.O. Box 3020, Mississauga STN A
Mississauga, ON L5A 4M2

Attending Physician Statement
Disability Claim Only

Section 1 – Patient Authorization

☐ Mr. ☐ Mrs. First Name

☐ Ms ☐ Miss Last Name Date of Birth (DD/MM/YYYY)

Mailing Address

Number Street

City Province select Postal Code Telephone Number

I authorize my doctor to use and exchange information with Sun Life Assurance Company of Canada, its agents and service providers for the purposes of underwriting, administration and adjudicating my claim and with CIBC as Administrator under this Plan. I agree that a photocopy of this authorization is as valid as the original.

Date (DD/MM/YYYY) Name X Signature

Section 2 - Attending Physician Statement

Note: Any charge for completion of this form is the responsibility of the claimant.

History

Date symptoms first appeared or accident happened (day, month, year)

Date patient became disabled (day, month, year)

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

Has patient ever had same or similar condition? ☐ No ☐ Unknown ☐ Yes

If Yes, state when and describe:

Is condition considered chronic? ☐ No ☐ Yes

If Yes, what precipitated absence from work?

Names and addresses of other treating physicians

Cause of Disability

Primary (including any complications)

Diagnosis

Additional conditions or complications which might affect duration of absence from work

Subjective symptoms

Objective signs (including results of current x-rays, EKG'S, MRI'S, CATSCANS or laboratory data and any relevant clinical findings). Please provide copies.

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

If relevant, blood pressure at time of latest attendance

Attending Physician Statement
Disability Claim Only

Current Functional Limitations

1. Function — Degree of limitation

	None	Slight	Moderate	Severe	Don't Know
Cognition	☐	☐	☐	☐	☐
Speaking	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Sensation	☐	☐	☐	☐	☐
Psychological	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Lifting	☐	☐	☐	☐	☐

Degree of limitation

	None	Slight	Moderate	Severe	Don't Know
Dexterity	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐

Please add any other functions limited by the illness or injury:

	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

Please indicate max. recommended weight ☐ lb ☐ kg

2. Describe any functional limitations, physical or psychological, which you consider to be major obstacles to the person's ability to work.

3. Were any functional capacity evaluations performed? ☐ No ☐ Yes

If Yes, state type

If Yes, when (DD/MM/YYYY)

Treatment

Date of first visit (day, month, year)

Date of latest visit (day, month, year)

Frequency of visits ☐ Weekly ☐ Monthly ☐ Other, specify

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

To your knowledge is patient following recommended treatment program? ☐ Yes ☐ No

If No, please comment

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Attending Physician Statement
Disability Claim Only

Progress

Has patient ☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed

Please comment

Prognosis

If patient is pregnant, please indicate estimated date of confinement (dd/mm/yyyy)

Is patient now totally disabled from own occupation?

☐ Yes, state date you think patient will be able to resume work (day, month, year)

☐ No, state date patient was able to work (day, month, year)

If indefinite, estimate ☐ 1 - 3 months ☐ 4 - 6 months ☐ over 6 months ☐ never

Is patient a suitable candidate for some trial employment or rehabilitation? ☐ No ☐ Yes, state date (day, month, year)

Has patient been referred to another doctor? ☐ No ☐ Yes, dates referred

Name (specialty) and address

Remarks

Attending Physician Statement
Disability Claim Only

This form may be mailed directly to Sun Life Assurance Company of Canada or given to the patient at the physician's discretion.

Name of Attending Physician
(please print)

Specialty

Telephone Number | Fax Number

Mailing Address

Number | Street

City | Province select | Postal Code

Date (DD/MM/YYYY) | Name | X Signature

Please submit to

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