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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.

Deceased's Authorized Representative

Complete the first section on this form as the deceased's authorized representative and give to deceased's family physician for completion. Include original or notarized copy of proof of death and send to Sun Life Assurance Company of Canada, c/o Creditor Insurance Customer Service as instructed below in the "Where to send claim(s)". For accidental death, attach Coroner's Report, Autopsy Report, and Police Accident Report if available. Be sure to retain copies of all documents for your files.

Family Physician

Complete and sign indicated section of this form. Return completed form to the authorized representative.

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

This section to be completed by Deceased's Authorized Representative

Name of Deceased - Surname _____ Initials _____

First Name _____ Gender ☐ M ☐ F

Details of other life insurance of deceased with Sun Life Assurance Company of Canada and policy number _____

Name of Deceased's Authorized Representative _____

Relationship to Deceased (e.g. next of kin, executor/ executrix, etc.) _____

Address _____

City _____ Province select Postal Code _____ Telephone Number _____

I authorize and direct any medical practitioner, hospital or clinic, or medically related facility, insurance company, law enforcement agency or other organization, institution or person that has, or may in the future have, any record or information regarding the above named deceased (including any record or information regarding psychologically related and HIV/AIDS related conditions) to release any such records or information to Sun Life Assurance Company of Canada, Canadian Imperial Bank of Commerce ("CIBC") or any of their designated administrator 's for the purpose of the underwriting process or the adjudication of this claim. A photographic copy of this authorization shall be valid as the original.

_____ _____ X _____

Date (DD/MM/YYYY) Name Signature

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This section to completed by Family Physician

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

Name of Deceased - Surname _____ Initials _____

First Name _____ Date of Birth (DD/MM/YYYY) _____

Date of Death (DD/MM/YYYY) _____ Place of Death _____

Date of diagnosis of condition causing death (DD/MM/YYYY) _____ Immediate Cause _____

Date of first treatment for condition causing (DD/MM/YYYY) _____ Contributory Cause(s) _____

Date of Last Treatment (DD/MM/YYYY) _____ Manner of death ☐ Accident ☐ Suicide ☐ Natural Causes

Deceased has been a patient since (day, month, year) _____ Provide additional details _____

Was an inquest held? ☐ Yes ☐ No Was an autopsy performed? ☐ Yes ☐ No

If yes, by whom and what were the findings (attach findings):

_____

Give details of any conditions for which you treated the deceased during the 12 months prior to death whether or not related to the cause of death.

Date	Diagnosis	Treatment Prescribed	Type of Surgery, if any

Name of Family Physician (please print) _____ Telephone Number _____

Address (number and street) _____

City _____ Province select Postal Code _____

Name and Address of any other doctors who, to your knowledge, may have treated the deceased prior to death (attach note if insufficient space)

_____

_____ _____ X _____

Date (DD/MM/YYYY) Name Signature of Family Physician

These statements are true and complete to the best of my knowledge.

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