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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
  - Your proof of Employment Insurance
  - Your proof of Strike Pay (Union Letter) for job loss claims related to strike or lock-out, if your job loss coverage was effective prior to November 1, 2022
  - Your proof of Unemployment Benefit or Service Canada Letter regarding severance package

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)

Email: Call the Creditor Helpline at 1 800 465-6020 to set up secured email.

Mail: CIBC Insurance, PO Box 3020, Mississauga STN A, Mississauga, ON L5A 4M2

PO Box 603, STN Agincourt Scarborough ON M1S 5K9
1-888-723-8881 simplii.com

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 it 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.

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Email: Call the Creditor Helpline at 1 800 465-6020 to set up secured email.

Mail: CIBC Insurance, PO 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 _____

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

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 _____

Cell Number (Optional) _____ Email Address (Optional) _____

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 The Canada Life Assurance Company or Canadian Imperial Bank of Commerce ("CIBC") as administrator or any of their designated administrator's for the purpose of the underwriting process or the adjudication of this claim or the administration of this insurance. A photographic copy of this authorization shall be valid as the original.

_____ _____ X _____

Date (Month day, year) Name Signature (sign within box)

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 (Month day, year)

Date of Death (Month day, year) | Place of Death

Date of diagnosis of condition causing death (Month day, year) | Immediate Cause

Date of first visit for condition causing death within the 12 month period prior to date of death (Month day, year) | Contributory Cause(s)

Date of Last Treatment (Month day, year) | Manner of death ◯ Accident ◯ Suicide ◯ Natural Causes ◯ Others

Deceased has been a patient since (Month day, 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)

Date (Month day, year) | Name | X | Signature of Family Physician (sign within box)

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

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