PRINT

CLEAR FORM

simplii FINANCIAL

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

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

Creditor Insurance for Simplii Financial personal lines of credit and loans is underwritten by The Canada Life Assurance Company (Canada Life) and administered by Canada Life and Canadian Imperial Bank of Commerce. You may contact Canada Life at 1-800-387-4495 or visit www.canadalife.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.

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

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 administrators 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)

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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 (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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Claimant information

Title First Name

Last Name Date of Birth (Month day, year) Gender

Mailing Address

Number Street

City Province select Postal Code Telephone Number

Cell Number (Optional) Email Address (Optional)

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 (Month day, year) From To

Brief job description Telephone Number

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

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

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

Name and address of employer Telephone Number

First day worked (Month day, year) Last day worked (Month day, 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 Number

☐ E.I. (provide date you registered for E.I. benefits) (Month day, year)

☐ Canada or Quebec Pension Plan

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

☐ Individual insurance coverage (provide company name and policy number)

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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 (Month day, year)

Location of accident ◯ Work ◯ Elsewhere (specify)

How did accident happen/cause of disability

If MVA, include police report

Date illness began (Month day, 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 (Month day, 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 The Canada Life Assurance Company may investigate this claim. I authorize The Canada Life Assurance Company, 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 (Month day, year) | Name | X Signature (sign within box)

Please submit to:

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

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Creditor Disability or Job Loss Claim
Employer Statement

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 (Month day, year)

Date last worked (Month day, year)

Reason for discontinuing work

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

Date expected to return to work ◯ Full-time ◯ Part-time (Month day, year)

OR Date returned to work ◯ Full-time ◯ Part-time (Month day, year)

Did employee receive severance? ◯ No ◯ Yes, date severance ends (Month day, 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: (Month day, 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 (Month day, year)

Name

X

Signature (sign within box)

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Attending Physician Statement
Disability Claim Only

Section 1 – Patient Authorization

Title First Name

Last Name | Date of Birth (Month day, year) | Gender

Mailing Address

Number Street

City | Province select | Postal Code | Telephone Number

Cell Number Email Address (Optional)

I authorize my doctor to use and exchange information with The Canada Life Assurance Company, 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 (Month day, year) | Name | X Signature (sign within box)

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
(Month day, year)

Date patient became disabled
(Month day, 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

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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

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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 (Month day, year)

Treatment

Date of first visit for the condition causing disability within the 12 month period prior to the date of total disability (Month day, year)

Date of latest visit (Month day, 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 delivery (Month day, year)

Is patient now totally disabled from own occupation?

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

◯ No, state date patient was able to work (Month day, 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 (Month day, year)

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

Name (specialty) and address

Remarks

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Attending Physician Statement
Disability Claim Only

Name of Attending Physician
(please print)

Specialty

Telephone Number | Fax Number

Mailing Address

Number | Street

City | Province select | Postal Code

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

Please submit to

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