Critical Illness Insurance Claim

When should a Critical Illness Insurance claim be made?

- If you are insured under Critical Illness Insurance for CIBC Mortgages, and
- You have suffered a Critical Illness as defined in your Certificate of Insurance

What information is required for a Critical Illness Insurance claim?

☐ The following sections of this claim form: **Claimant Statement** and the **Attending Physician Statement**; and

☐ If the insured client is deceased, the original or notarized copy of proof of death.

How to find the mortgage number?

- Sign on to CIBC Online or Mobile Banking and go to "My Accounts".
- View your mortgage statements
- Contact your banking centre advisor

Where to submit the claim forms?

- **Email : Call the Creditor Helpline at 1 800 465-6020 to set up secured email**
- **Mail : CIBC Insurance, P.O. Box 3020, Mississauga STN A, Mississauga, ON L5A 4M2**
- **Fax : 1 877 735-4900 or 905 306-4900**

Note: Any missing information may cause your claim to be delayed

What happens after a Claim is submitted?

- You are responsible for your Mortgage loan payments and insurance premiums until the claim is approved;
- You will be advised if further information is required to process your claim;
- On approval of your claim, The Canada Life Assurance Company (Canada Life) will make your benefit payment to CIBC. A notice will be sent to you indicating the payment made;
- If your claim is denied Canada Life will advise you in writing.

Do you need more information?

- Refer to your Certificate of Insurance for information about the terms, conditions, limitations, exclusions and other provisions of your coverage,
- ***Call the Creditor Helpline at 1 800 465-6020***
- ***You may contact Canada Life at 1 800 387-4495 or visit www.canadalife.com***

Your Privacy Matters - a note from the Insurers

- Creditor Insurance for CIBC Mortgages is underwritten by The Canada Life Assurance Company (Canada Life). This insurance product is administered by Canada Life and CIBC, and is subject to certain terms, conditions, limitations and exclusions, which are set out in the Certificates of Insurance, which are provided upon enrolment.
- When you requested coverage, you gave Canada Life personal information about yourself, which Canada Life added to a client file. The purpose of this file, which is strictly confidential, is to allow Canada Life and their reinsurers to conduct all the necessary business of insurance, including, setting fair premiums, receiving payments, assessing and paying claims, and keeping you informed of the status of your coverage. Canada Life keeps client files at their head office or at another secure location authorized by Canada Life.
- Only authorized personnel have access to personal information about you. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. If you want to know or correct any personal information in your claim file, just call the Creditor Helpline at **1 800 465-6020** and we will be happy to assist you.

Claimant Statement – Section 1 of 2

Preferred language correspondence ☐ English ☐ Français

Information about your Lending Product

Please complete the information below for each lending product.

	Mortgage 1	Mortgage 2	Mortgage 3
Mortgage Number			
Is there also Life Insurance for this Mortgage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Information about your Banking Centre *(optional)*

Banking Centre Officer Name	Transit #
Address	Telephone #

Information about the Claimant

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

First Name | Initial | Last Name

Date of Birth (day, month, year) | Gender ☐ Male ☐ Female

Telephone # | Cell # *(optional)* | Email address *(optional)*

Mailing Address (Number and Street) | City | Province | Postal Code

Continued on next page

CLAIMANT STATEMENT – Section 2 of 2

A. Claimant Authorization to Release Personal Information *(optional)*

If you wish to authorize someone other than yourself (such as a family member or friend) to communicate with The Canada Life Assurance Company on your behalf with respect to your claim, please complete this Authorization Form. Communication will be limited to matters related to the claim for benefits. This authorization shall remain valid for the duration of the claim for benefits or until otherwise revoked by you.

I authorize Canada Life to communicate personal information that relates to my claim for benefits with:

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

First Name of appointed person | Initial | Last Name

Relationship

Telephone # | Cell # *(optional)* | Email address *(optional)*

Address (Number and Street) | City | Province | Postal Code

Please select one option (If no selection, medical information will not be released to the authorized appointed person)

☐ Excluding medical information ☐ Including medical information

B. Signature and Authorization – Must be completed by the claimant

I certify that the statements in this form are true and complete. I understand that The Canada Life Assurance Company will investigate the claim. I authorize Canada Life, its agents and service providers to collect, use and exchange personal information about me needed by it for administration and adjudication of claims and by CIBC for the purpose of administering my claim under these Group Policies, with any person or organization who has relevant information pertaining to this claim, including health professionals, institutions, investigative agencies, insurers and reinsurers and administrators of government benefits and other benefits programs. I authorize the use of my information collected in relation to this mortgage insurance claim for the purposes of reviewing and administering any other coverage I may have with respect to the insured mortgage. Canada Life may contact me using the contact information I have provided above, for the purposes of administering this claim.

A photocopy of this authorization shall be as valid as the original and shall continue to have effect throughout my claim.

X

Date (mm/dd/yyyy) | Name | Signature (sign within box)

Attending Physician Statement *(Note: Any charge for completion of this form is the responsibility of the claimant)*

Patient Information

First Name | Initial | Last Name

Date of Birth (day, month, year) | Diagnosis

Date symptoms first appeared (day, month, year) | Exact Date of First diagnosis (day, month, year)

Has the patient ever had a similar condition?
☐ Yes ☐ No

If yes, please give details (i.e. date of first symptoms, date of diagnosis, duration, etc.)
From: To:

Has the patient ever been hospitalized?
☐ Yes ☐ No

If yes, provide length of stay (day, month, year)
From: To:

Hospital Name | Hospital Telephone #

Please tell us any additional information which would help us assess this claim.

Please attach copies of all specialist consultation notes, admission/discharge records relating to the cause of claim. For the following conditions, please ensure attached documentation includes but is not limited to:

Heart Attack: ECG's from the day of event and lab results supporting diagnosis including previous and new cardiac enzyme levels.

Stroke: Diagnostic evidence supporting stroke diagnosis and current neurological deficits that have been present for over 30 days.

Cancer: Diagnostic evidence to confirm malignant neoplasm including relevant pathology report.

Name of Attending Physician | Specialty

Name of Facility (Hospital, Medical Centre)

Address (Number and Street) | City | Province | Postal Code

Telephone # | Fax #

By signing here, you acknowledge that the answers given above are true and complete to the best of your knowledge.

X

Date (mm/dd/yyyy) | Name of Attending Physician's | Signature of Attending Physician's (sign within box)

***Please return this form to your patient*.**