iA Dealer Services

Life and Health Claims Department
Mailing address: PO Box 5900, Vancouver (BC) V6B 5H6
Street address: 400-988 Broadway West, Vancouver (BC) V5Z 1K7
Toll free: 1 800 549-7227
Fax: 1 833 733-9519 / 604 733-9519

Creditor Claim — Critical Illness
Application Kit

The Application Kit contains: an instruction sheet plus forms that need to be completed to apply for Critical Illness benefits, and some important information about the claims process itself.

Please keep this instruction sheet for your future reference.

The Application Kit includes the following forms, which must be completed and submitted within 90 days of onset of Critical Illness:

A Claimant's Statement – Preliminary Proof of Loss

B Authorization and Declarations

C Attending Physician's Statement

D Certificate and Financial Institution Information

Please also provide a copy of your Birth Certificate or Driver's License as well as a copy of the loan history details from the Finance Company from the onset of the loan to the present.

A Claimant's Statement – Preliminary Proof of Loss
This form requests information about you. Please complete all sections fully. If you have additional information that has not been requested which you feel is pertinent to your claim, please provide as an attachment.

B Authorizations and Declarations
We need your permission to obtain information that will help us assess your claim. By signing this Authorization and Declarations form, you give Industrial Alliance Insurance and Financial Services Inc. ("Industrial Alliance") consent to obtain information from your Physicians, other insurers and Healthcare Providers and others as described in the Authorization. You also confirm that any subsequent information you provide in person or by telephone will be true and complete.

C Attending Physician's Statement
Your primary care Physician or Treating Physician must complete this form and attach copies of consultation reports, investigation and test results. This provides us with information about your Critical Illness, its onset, and your medical history. You are responsible for any fees your Physician may charge for preparing the forms.

D Certificate and Financial Institution Information
This form requests important information regarding your certificate, Financial Institution and loan. Please complete the applicable sections and be sure to include the Certificate Number(s). If you have more than one loan insured against Critical Illness with Industrial Alliance, please provide separate information in the additional section provided or on a separate sheet. This form also enables us to exchange information, of a non-medical nature, with your dealership and Financial Institution.

Before submitting your claim:

- Please ensure that you have read your Certificate of Insurance carefully, particularly the section entitled "LIMITATIONS AND EXCLUSIONS".
- Please ensure that you have read all the instructions and that all the relevant sections of the Creditor Critical Illness Claim Application Kit have been completed by you and your attending Physician(s).
- Please check for completeness as incomplete documentation may cause delays.

To ensure your claim is processed promptly:

- Submit your claim to Industrial Alliance at the address indicated at the top of the claim forms. Please do not fax the forms but send them by mail or courier.
- As our Medical Directors do not examine you, we depend on the quality of the medical information given by your Physician(s) to assess your claim.
- We recommend that you submit your claim as soon as possible to avoid unnecessary delays.

Upon receipt of your claim:

- Industrial Alliance Insurance and Financial Services Inc. (Industrial Alliance) evaluates the information included on the application forms to determine your eligibility to claim based on the Certificate of Insurance provisions and the medical evidence provided and obtained.
- We may find it necessary to correspond directly with your Physician(s) for additional medical information to assess your eligibility for benefits.
- Please be advised that we may need to contact you in the future for any additional signed medical authorizations requested by a Physician.
- Upon receipt of all original application forms, we will notify you within 10 business days:
  - If more information is required, or
  - That your claim is approved and paid, or
  - If your claim cannot be processed and the reasons why.

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Creditor Claim — Critical Illness

Application Kit (con't)

Important notes and answers to some frequently asked questions:

- You are responsible for any costs associated with providing the initial proof of claim, including the cost of medical information provided by your Attending Physician. When Industrial Alliance requests information directly from your Physician(s), we will offer to pay a correspondence fee for it.
- A **Doctor of Medicine** must complete the Attending Physician's Statement.
- We remind you that it remains your responsibility to continue to make payments to your Financial Institution until your claim is accepted. Therefore, we recommend that you contact your Financial Institution to make any arrangements to ensure that you do not default on your obligation.
- If your claim is accepted, the benefit amount will be the lesser of the following amounts:
  - The outstanding balance of your Insured Loan on the date the Critical Illness was diagnosed, following a notice from the creditor, less any arrears in payments;
  - In the case of a lease contract, the present value of your outstanding payments and the residual value indicated in your insurance proposal, if applicable;
  - The maximum provided for under the plan.
- Benefit payment is made directly to the Financial Institution, to reduce your financial obligation under the Loan. We notify you of any payment made.
- Please be advised that the Certificate of Insurance does not cover costs related to late or default on payment, or loan extensions.
- You should feel free to call us if you have any questions about your claim or the claims process. One of our Customer Service Representatives will be pleased to answer your questions.
- If you are unable to reach us immediately, please leave a message. We strive to return all calls within one business day.

YOU CAN CONTACT US AT:

Industrial Alliance Insurance and Financial Services Inc.

Life and Health Claims Department

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A Creditor Claim — Critical Illness

Claimant's Statement – Preliminary Proof of Loss

Please print in ink.

Certificate Number(s)

IDENTIFICATION AND CONTACT INFORMATION

Surname | Initials | First Name | ☐ Mrs ☐ Ms ☐ Mr

Address - Street | City | Province | Postal Code

Date of Birth (yyyy-mm-dd) | Provincial Health Care Number | Email

Home Telephone | Mobile Telephone | Work Telephone | Extension

INFORMATION ABOUT YOUR HEALTH

Describe the type of Critical Illness or type of surgery

Date of diagnosis or surgery (yyyy-mm-dd)

Description of first symptoms

Date when first symptoms began (yyyy-mm-dd)

First Doctor, Hospital, and/or Clinic seen for this condition:

Name | Address | Telephone

Date of first medical visit for this condition (yyyy-mm-dd)

Have investigations been carried out? ☐ Yes ☐ No If yes, please indicate where the investigations took place:

Name of Health Institution | Address | Telephone

Name of Physician who made the diagnosis

Names of all other Physicians, Specialists, Clinics and Hospitals seen for your condition:

Name of Physician/Clinic/Hospital | Address | Telephone

What treatment(s) have you received, or will you be receiving for this condition?

Have you had the same, similar or related condition in the past? ☐ Yes ☐ No

If yes, please provide details and dates (yyyy-mm-dd) :

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A Creditor Claim — Critical Illness

Claimant's Statement – Preliminary Proof of Loss (con't)

PHYSICIAN AND HOSPITAL INFORMATION

Name of Physician(s) Treating your Critical Illness:

Name	Address	Telephone	Fax	How long have you attended this Doctor or this Clinic?

Name of Your Primary Personal Physician/family Doctor:

Name	Address	Telephone	Fax	How long have you attended this Doctor or this Clinic?

List the Physicians, Medical Clinics and/or Hospitals you attended, provide the date and reason for consultation for the last 12 months to the present. If you run out of space, attach a separate sheet of paper.

Name of Physician, Clinic or Hospital	Address	Date (yyyy-mm-dd)	Reason for consultation

List all pharmacies where you have had a prescription filled for the last 12 months to the present:

Name of pharmacy	Address	Telephone	Fax

INFORMATION ABOUT YOUR OTHER INSURANCE BENEFITS

If you are receiving other insurance benefits, provide us with the following information:

Company Name	Type of benefit	Claim Number	Contact Person and Telephone

I hereby certify that all the information contained in this declaration is accurate and complete and that any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as the result of this claim.

Name of Claimant (Please print)	X Signature	Date (yyyy-mm-dd)

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B Creditor Claim — Critical Illness
Authorization and Declarations

Please print in ink.

Protecting the Privacy of Your Personal Information

At Industrial Alliance Insurance and Financial Services Inc. (the "Company"), we recognize and respect every individual's right to privacy. Personal information about you is kept in a confidential claim file at the offices of the Company or the offices of an organization authorized by the Company in a secure area. We limit access to information in your files to our staff or persons authorized by the Company who require this access to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

We use this information to investigate and assess your claim and to administer the Certificate of Insurance provisions.

You may access the personal information contained in your file and correct any inaccurate information. Any personal health information will be provided to you through a medical practitioner of your choice. To view your personal information please send a request in writing to the attention of the Claims Department at the above address, together with the name of the Medical practitioner.

PLEASE SIGN BOTH AUTHORIZATIONS AND DECLARATIONS

Authorization and Declarations

I hereby authorize Industrial Alliance Insurance and Financial Services Inc. (the "Company"), any Healthcare Provider, my employer, other insurance companies or other organizations, institutions, administrators of government benefits or persons possessing records or knowledge of me or benefit service providers working with the Company to release and exchange any of my personal and personal health information, when necessary to investigate and assess my claim and administer the terms of the Certificate of Insurance.

I understand that the personal information obtained using this authorization will be used by the Company in the evaluation of a claim for benefits. Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

This authorization shall remain valid for the duration of my claim for benefits or until otherwise revoked by me.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

I declare that the information provided in the Claimant's Statement is accurate and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as the result of this claim.

Name of Claimant (Please print)	X Claimant Signature	Date (yyyy-mm-dd)

Authorization and Declarations

I hereby authorize Industrial Alliance Insurance and Financial Services Inc. (the "Company"), any Healthcare Provider, my employer, other insurance companies or other organizations, institutions, administrators of government benefits or persons possessing records or knowledge of me or benefit service providers working with the Company to release and exchange any of my personal and personal health information, when necessary to investigate and assess my claim and administer the terms of the Certificate of Insurance.

I understand that the personal information obtained using this authorization will be used by the Company in the evaluation of a claim for benefits. Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

This authorization shall remain valid for the duration of my claim for benefits or until otherwise revoked by me.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

I declare that the information provided in the Claimant's Statement is accurate and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as the result of this claim.

Name of Claimant (Please print)	X Claimant Signature	Date (yyyy-mm-dd)

Certificate Number(s)

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C Creditor Claim — Critical Illness

Attending Physician Statement

Please print in ink.

SECTION 1 — PATIENT TO COMPLETE THIS AUTHORIZATION

This is not a request for examination but for information taken from your chart. The patient is responsible for securing this form and any charges for its completion.

Name of patient | Certificate Number(s) | Date of Birth (yyyy-mm-dd)

I hereby authorize the release of any information requested on this form to the Industrial Alliance, Insurance and Financial Services Inc. or any of its agents.

X
Signature of patient | Date (yyyy-mm-dd)

SECTION 2 — TO BE COMPLETED BY THE PHYSICIAN

Diagnosis | Date diagnosis confirmed (yyyy-mm-dd)

Date of onset of first symptoms (yyyy-mm-dd) | Description of first symptoms

Date of first medical visit related to this condition (yyyy-mm-dd) | Location of first medical visit (Family Doctor, Emergency Room, Walk-in Clinic etc.)

Did your patient attend the Hospital Emergency? ☐ Yes ☐ No

Was your patient hospitalized? ☐ Yes ☐ No

Please attach a copy of the Admission and Discharge Summary. If not available, then please indicate:

Name of Hospital | Date of admission (yyyy-mm-dd) | Date of discharge (yyyy-mm-dd)

Surgery performed or planned? ☐ Yes ☐ No

Procedure: | Date (yyyy-mm-dd)

Name of Surgeon | Specialty (if applicable)

To assist us in promptly assessing your patient's claim, **please include copies of relevant consultation reports, investigation and test results which confirm the diagnosis, including:**

Cancer	Heart Attack	Stroke	All other conditions
• Pathology reports • Specialist consultation reports • All other relevant reports detailing: — Histology & Staging — Site, Type, Size & Depth of Tumor — Adjacent tissue invasion, Lymph node involvement and/or Metastases	• Evidence of a Myocardial Infarction • Specialist Consultation reports • Electrocardiographic, Angiographic, Echocardiogram studies • Laboratory test results, including cardiac biochemical markers, cardiac enzymes • Operative reports	• Evidence of a cerebrovascular event • Neuroimaging scans such as CT Scan and/or MRI • Specialist consultation reports • Neurological assessments • Evidence of neurological sequelae lasting more than 30 days	• All other relevant reports confirming diagnosis • Operative reports • For burns, degree and % of body surface • For blindness, visual acuity before and after correction for both eyes • For major organ failure, date patient was placed on an organ transplant list in Canada

Describe the current and planned treatment(s)

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C Creditor Claim — Critical Illness

Attending Physician Statement (con't)

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

If yes, please provide dates, diagnosis, and treatment received:

Date (yyyy-mm-dd)	Treatment(s) received

If the diagnosis is related to Cardiovascular Disease (Myocardial Infarction, Coronary Artery Bypass Grafting, Stroke), please indicate the date on which the symptoms first appeared, or heart problems (CAD, old MI or other) or vascular (Atherosclerosis, AIT, etc.) were first diagnosed.:

Date (yyyy-mm-dd)

Please provide all dates of treatment, medical advice, consultation, service, attendance for the **last 12 months to the present**. (Alternatively, you may include a **complete** copy of your patient's medical records, including clinical notes, consults, test results for the last 12 months to the present):

Are notes enclosed? ☐ Yes ☐ No

Date (yyyy-mm-dd)	History/physical findings	Diagnosis	Treatment

List of medication and treatment prescribed for the last 12 months to the present:

Medication	Prescribed for	Date first prescribed (yyyy-mm-dd)	Date ceased (if applicable) (yyyy-mm-dd)

Date patient was first under your care (yyyy-mm-dd)	If patient was referred to you, name the referring Physician	Date referred (yyyy-mm-dd)

Any other comments

Physician Name (Please print)	Specialty

Address	Telephone	Fax

X _____ _____

Physician's Signature | Date (yyyy-mm-dd)

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D Creditor Claim — Critical Illness

Certificate and Financial Institution

Please print in ink.

To be completed by Claimant

CERTIFICATE AND DEALERSHIP — 1ST LOAN

Selling Dealership or Broker | Certificate Number | Date of Purchase (yyyy-mm-dd)

Telephone | Fax | Email | Province | Postal Code

FINANCIAL INSTITUTION — 1ST LOAN (WHERE LOAN IS BEING HELD)

Name | Loan Number and/or VIN | Loan Payment Day

Address | City | Province | Postal Code

Contact | Telephone | Fax | Email

Payment Amount | Frequency

$ ☐ Monthly ☐ Bi-weekly ☐ Weekly ☐ Other:

CERTIFICATE AND DEALERSHIP — 2ND LOAN (IF MORE THAN 1 LOAN)

Selling Dealership or Broker | Certificate Number | Date of Purchase (yyyy-mm-dd)

Telephone | Fax | Email | Province | Postal Code

FINANCIAL INSTITUTION — 2ND LOAN

Name | Loan Number and/or VIN | Loan Payment Day

Address | City | Province | Postal Code

Contact | Telephone | Fax | Email

Payment Amount | Frequency

$ ☐ Monthly ☐ Bi-weekly ☐ Weekly ☐ Other:

I hereby authorize Industrial Alliance Insurance and Financial Services Inc. (Industrial Alliance) to release to my Financial Institution or selling dealership, in relation to this Certificate of Insurance, or if more than one, Certificates of Insurance, any **non-medical information** regarding the status of my claim.

If you have more than two loans insured with iA, you may wish to take a photocopy of this page to provide information regarding the additional loans or simply provide it on a blank sheet of paper.

Name of Claimant (Please print) | X Signature | Date (yyyy-mm-dd)

Any Creditor insurance benefits payable will be paid directly to the Financial Intuition where the loan is held.

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E Creditor Claim — Critical Illness

Employer's Statement

Please print in ink.

If self employed, complete Form E2

EMPLOYER : Complete Sections 1 and 2 and Sign at bottom.

Employee's name

Certificate Number(s)

SECTION 1

Name of company | Telephone | Fax | Email

Address | City | Province | Postal Code

Date employee commenced with your company (yyyy-mm-dd) | Annual income $

Employment type: Permanent ☐ Full-time ☐ Part-time* ☐ Casual ☐ Temporary ☐ Seasonal* ☐ Contract ☐ Other**:

* If seasonal or part-time, please describe below employee's schedule and average number of hours worked per week.

** If other, please describe the nature of employment relationship, schedule and average number of hours worked per week.

Hours worked per week

Is the employee assigned to different shifts?
☐ Yes ☐ No If different shifts, please provide details:

Job title

Please attach copy of the job description or describe what the principal job duties are and how much time is allocated to each duty during the week:

Duty	% of time spent	Duty	% of time spent

Date of employee's last working day (yyyy-mm-dd)

Reason:
☐ Layoff ☐ Strike ☐ Lock-out ☐ Disability ☐ Other:

SECTION 2

Was this a work-related injury?
☐ Yes ☐ No

Has it been approved by WCB or equivalent?
☐ Yes ☐ No If yes, please indicate the dates:

Has the employee worked any days since the date of disability?
☐ Yes ☐ No If yes, please indicate the dates (yyyy-mm-dd):

On what date, did you or will you resume work: Full-time (yyyy-mm-dd) | Part-time (yyyy-mm-dd)

I certify that the above information contained in this declaration is true, correct and complete to the best of my knowledge and belief.

Name of employer (Please print) | X Signature | Date (yyyy-mm-dd)

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E2 Creditor Claim — Critical Illness

Self-Employment Statement

Please print in ink.

COMPLETE ONLY IF SELF-EMPLOYED

Name of Insured

Certificate Number(s)

Complete name of your company

Provincial/Federal Business Number(s)

Complete address of your company

City

Province

Postal Code

Telephone

Fax

Email

Website

Is your company still in operation? ☐ Yes ☐ No

Is there more than one location for your business? ☐ Yes ☐ No If yes, please provide addresses and phone numbers:

Address | City | Province | Postal Code | Telephone

Do you own or operate any other businesses? ☐ Yes ☐ No If yes, please provide details:

Your job title(s)

Is your business a: ☐ sole proprietor ☐ partnership ☐ corporation

Date when you became owner/proprietor of the company

Nature of business, including products and services

Do you have any employees? ☐ Yes ☐ No If yes, number of employees (excluding yourself)

Are the operations of your business seasonal in nature? ☐ Yes ☐ No If yes, please provide details:

Please indicate annual gross revenues for the last 4 years:

Current year $ | Year 2 $ | Year 3 $ | Year 4 $

What are your principal job duties and how much time is allocated to these duties in a week?

Duty | Number of hours per week | Duty | Number of hours per week

What duties are you currently still performing?

Number of hours per week

Please describe the specific duties that are you currently unable to perform due to your disability

If you are unable to perform any duties, please indicate the date you last worked (yyyy-mm-dd)

Are other persons responsible for the duties that you are unable to perform due to your disability? ☐ Yes ☐ No

If yes, are they being paid? ☐ Yes ☐ No ☐ New hires ☐ Existing employees ☐ Other:

Please provide any other information you deem appropriate about your business

I certify that the above information contained in this declaration is true, correct and complete to the best of my knowledge and belief.

Name of Claimant (Please print)

X Signature

Date (yyyy-mm-dd)