



# Critical Illness Benefit

## Claim Information and Documents Required

- Before you submit your claim, you may wish to review your Critical Illness coverage\* to ensure that the condition you wish to claim for is a condition covered by your policy.
- You may also wish to review the other terms and conditions of your Critical Illness coverage\*, such as whether your policy contains a waiting period, limitations and/or exclusions.
- The claimant is responsible for having the required forms completed at their own expense.
- The Attending Physician’s Statement must be completed by a Licensed Medical Doctor (MD). As our Medical Directors do not examine you, we rely on the quality of the medical information given by your physicians to assess your claim. Please ensure that your physician includes copies of all specialist consultation, investigation and test results which confirm your diagnosis. The medical information we require is listed on the Attending Physician Statement.
- We recommend you keep a photocopy of the completed forms and authorization for your records and submit your claim as soon as possible as there may be a time limitation on your policy.
- To ensure prompt handling of your claim, please ensure you provide your policy number and policyholder name, and the required supporting documentation is provided at the time of claim.
- Please note that this list is not exhaustive, we may request additional medical information from your physician to complete our assessment of your claim.
- Submit all forms together to the Company at the address below. You may also send your claim forms by fax. We wish to remind you that email is not a secure method of communication and should only be used to transmit non-confidential information.

**\* The document which describes your coverage may be called an Insurance Certificate or a Summary of Insurance.**

**! Claim Form must be completed with all the Supporting Documents Required**

| BENEFIT CLAIMING FOR                     | SUPPORTING DOCUMENTS REQUIRED  |
|--|--|
| <b>Voluntary Critical Illness</b>        | <input type="checkbox"/> Completed Claim Form<br><input type="checkbox"/> Signed Authorization Form<br><input type="checkbox"/> Completed Attending Physician Statement<br>Provide copies of any medical information from your physician   |
| <b>Critical Illness through Employer</b> | <input type="checkbox"/> Completed Claim Form<br><input type="checkbox"/> Signed Authorization Form<br><input type="checkbox"/> Completed Attending Physician Statement<br>Provide copies of any medical information from your physician<br><input type="checkbox"/> Completed Certificate of Employer |

In providing claim forms for the convenience of the claimant, the Company does not admit any liability or waive any of the terms and conditions of the policy. Provision of this claim form does not indicate coverage. Only eligible claims will be paid.

**PLEASE RETURN ALL CLAIM FORMS AND SUPPORTING DOCUMENTATION TO OUR OFFICE BY MAIL OR FAX**

Industrial Alliance Insurance and Financial Services Inc.  
iA Special Markets (Claims Department)  
400-988 Broadway West,  
PO Box 5900, Vancouver, BC V6B 5H6

Tel 1 800-266-5667  
Fax 1 866-913-3620



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 Website ia.ca

# Critical Illness Benefit Claim Form

**!** To avoid any delays in processing of your claim, please send the duly completed claim form with all the supporting documents required.

## POLICY INFORMATION

|               |                   |   |   |
|---------------|-------------------|---|---|
| Policy Number | Policyholder Name | Original Effective Date of Coverage (dd-mmm-yyyy) | <input type="checkbox"/> Individual Insurance |
|               |                   |   | <input type="checkbox"/> Group Insurance      |

## CLAIMANT INFORMATION

|                          |                               |   |                             |                          |
|--------------------------|-------------------------------|---|-----------------------------|--------------------------|
| Last Name                | First Name                    | Sex   | Date of Birth (dd-mmm-yyyy) | Provincial Health Card # |
|                          |                               | <input type="checkbox"/> M <input type="checkbox"/> F |                             |                          |
| Unit Number              | Street Address                | City  | Province                    | Postal Code              |
|                          |                               |   |                             |                          |
| Home Phone               | Cell Phone                    | Email   |                             |                          |
|                          |                               |   |                             |                          |
| Occupation               | Work Phone                    | Employer Name   |                             |                          |
|                          |                               |   |                             |                          |
| Date Hired (dd-mmm-yyyy) | Last Day Worked (dd-mmm-yyyy) | Return to Work (or Expected) Date (dd-mmm-yyyy)       |                             |                          |
|                          |                               |   |                             |                          |

## HEALTH INFORMATION

|   |  |               |
|---|--|---------------|
| Type of Critical Illness or Type of Surgery   | Date of Diagnosis or Surgery (dd-mmm-yyyy)       |               |
|   |  |               |
| Description of First Symptoms   | Date of First Symptoms began (dd-mmm-yyyy)       |               |
|   |  |               |
| Date of First Medical Visit for This Condition (dd-mmm-yyyy)  | Name of Physician/Hospital/Clinic First Attended |               |
|   |  |               |
| Address of Physician/Hospital/Clinic  | Phone  |               |
|   |  |               |
| Did you have investigations? If Yes, please indicate below where the investigations took place: <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> |  |               |
| Name of Physician/Hospital/Clinic   | Address  |               |
|   |  |               |
| Name of Physician who made Diagnosis  | Phone  |               |
|   |  |               |
| Name of all other Physicians, Specialists, Clinics and Hospitals seen for your condition  | Addresses  | Phone Numbers |
|   |  |               |



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## Claim Form (con't)

What treatment have you received or will be receiving for this condition:

Have you had the same, similar or related condition in the past? If Yes, please provide details & dates:  Yes  No

Do you smoke or use tobacco products?  Yes  No

If Yes, please indicate: Amount per day \_\_\_\_\_ How long have you used tobacco? \_\_\_\_\_

Have you used tobacco products in the past?  Yes  No

If Yes, what date did you quit? (mmm-yyyy) \_\_\_\_\_

Has any blood relative suffered from a similar or related illness? If Yes, please indicate below:  Yes  No

| Relationship | Nature of illness | Age at which illness was diagnosed |
|--------------|-------------------|------------------------------------|
|              |                   |                                    |

### FAMILY PHYSICIAN INFORMATION

Name of your Family Physician \_\_\_\_\_ How long have you been with this physician? \_\_\_\_\_

Address of Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

If you have been with your Family Physician indicated above for less than 5 years, please list all Physicians, Medical Clinics or Hospitals seen in the last 5 years:

| Names of Physicians, Medical Clinics or Hospitals | Addresses | Phone Numbers |
|---|-----------|---------------|
|   |           |               |

Please provide any further information which you think might be helpful in support of your claim:

Claimant's Name (Please Print) \_\_\_\_\_

Signature of Claimant or Parent or Legal Guardian (if minor) \_\_\_\_\_ Date Signed (dd-mmm-yyyy) \_\_\_\_\_



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## Authorization and Declaration for Claim

### PRIVACY STATEMENT

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 of an organization authorized by the Company in a secure area. We limit access to information in your files to The Company 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, assess and administer your claim and the terms of the Insurance contract 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.

### AUTHORIZATION AND DECLARATION

I hereby authorize Industrial Alliance Insurance and Financial Services Inc., ("the Company") for the purposes of investigation, evaluation and administration of my claim:

- a) to gather only the information necessary for the above specified purposes from any person or organization that has personal information relating to me, including other insurers, reinsurers, and financial institutions; physicians, medical institutions and healthcare providers; employers or administrators of group benefits; agents or brokers; investigating and credit reporting agencies, and all persons or organizations likely to have personal information relevant to my claim.
- b) to disclose and exchange only the necessary personal information the Company has relating to me to the above persons and organizations.

I understand that the personal information obtained using this authorization will be used by the Company in the investigation, administration and 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.

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

**I declare that the information provided in the Claim Form 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.**

Claimant's Name (Please Print) \_\_\_\_\_

Signature of Claimant  
 or Parent or Legal Guardian (if minor) \_\_\_\_\_

Date Signed (yyyy-mm-dd) \_\_\_\_\_



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## Attending Physician Statement

### PATIENT AUTHORIZATION PATIENT TO COMPLETE

**!** 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.

|                      |                      |                             |
|----------------------|----------------------|-----------------------------|
| Policy Number        | Patient Name         | Date of Birth (dd-mmm-yyyy) |
| <input type="text"/> | <input type="text"/> | <input type="text"/>        |

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.

|                      |                           |
|----------------------|---------------------------|
| Patient Signature    | Date Signed (dd-mmm-yyyy) |
| <input type="text"/> | <input type="text"/>      |

### PHYSICIAN'S STATEMENT PHYSICIAN TO COMPLETE THE FOLLOWING

**!** In order 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:

| For Cancer   | For Heart Attack   | For all other conditions  |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Pathology reports</li> <li>• Specialist consultation reports</li> <li>• All other relevant reports detailing:               <ul style="list-style-type: none"> <li>— Site of Tumor</li> <li>— Type of Tumor</li> <li>— Size of Tumor</li> <li>— Depth of Tumor</li> <li>— Histology</li> </ul> </li> <li>— Staging</li> <li>— Adjacent tissue invasion</li> <li>— Lymph node involvement</li> <li>— Metastases</li> </ul> | <ul style="list-style-type: none"> <li>• Specialist Consultation reports</li> <li>• Echocardiograms</li> <li>• Laboratory test results, including cardiac biochemical markers, cardiac enzymes</li> <li>• Operative reports</li> <li>• Angiographic, Echocardiogram studies</li> </ul> | <ul style="list-style-type: none"> <li>• Specialist Consultation reports</li> <li>• Operative reports</li> <li>• CT Scans, MRI, X-Rays, etc.</li> <li>• Angiographic, Echocardiogram, Electrocardiograms studies</li> <li>• Laboratory test results</li> <li>• Neurological assessments</li> <li>• All other relevant reports confirming diagnosis</li> </ul> |

|                      |  |
|----------------------|--|
| Diagnosis            | Date Diagnosis Confirmed (dd-mmm-yyyy) |
| <input type="text"/> | <input type="text"/>                   |

|   |                           |
|---|---------------------------|
| Date of First Medical visit related to this condition (dd-mmm-yyyy) | Location of Medical Visit |
| <input type="text"/>  | <input type="text"/>      |

|                               |   |
|-------------------------------|---|
| Description of First Symptoms | Date of Onset of First Symptoms (dd-mmm-yyyy) |
| <input type="text"/>          | <input type="text"/>                          |

Did your patient attend the Hospital Emergency?  Yes  No

Was your patient Hospitalized? **If Yes, please attach a copy of the Discharge Summary** (if not available please provide details below).  Yes  No

|                      |                                 |                                 |
|----------------------|---------------------------------|---------------------------------|
| Name of Institution  | Date of Admission (dd-mmm-yyyy) | Date of Discharge (dd-mmm-yyyy) |
| <input type="text"/> | <input type="text"/>            | <input type="text"/>            |

Surgery performed or planned?  Yes  No

|                      |                      |
|----------------------|----------------------|
| Procedure            | Date (dd-mmm-yyyy)   |
| <input type="text"/> | <input type="text"/> |

|                      |                           |
|----------------------|---------------------------|
| Name of Surgeon      | Specialty (if applicable) |
| <input type="text"/> | <input type="text"/>      |

|                               |
|-------------------------------|
| Current and Planned Treatment |
| <input type="text"/>          |

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

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

|                      |
|----------------------|
| <input type="text"/> |
|----------------------|



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## Attending Physician Statement (con't)

If patient was referred to you, name the referring physician

Date Referred (dd-mmm-yyyy)

Family Physician's Name

Date patient was first under your care (dd-mmm-yyyy)

Names and specialties of other physicians who are or will be involved in your patient's care:

Name of Physician

Specialty

Date of Consultation (dd-mmm-yyyy)

Have any of your patient's blood relatives suffered from the same, a similar or related illness?  
 If Yes, please indicate below:

Yes  No  Unknown

Relationship

Nature of illness

Age at which illness was first diagnosed

Does your patient currently use tobacco or a tobacco substitute?

Yes  No  Unknown

Has your patient ever used tobacco or a tobacco substitute?

Yes  No  Unknown

If Yes, please indicate date stopped (mmm-yyyy)

Any other comments:

### PHYSICIAN INFORMATION PHYSICIAN TO COMPLETE THE FOLLOWING

Physician Name (Please print)

Specialty

Address

Telephone

Fax

Signature  
of Physician

M.D.

Date Signed  
(dd-mmm-yyyy)