Critical Illness Claimant's Statement

Instructions to the Claimant/Insured:

PLEASE PRINT IN INK

If someone other than the Insured is completing this form or part of this form, please provide the full name and relationship to the Insured.

- Complete, sign and date this Critical Illness Claimant's Statement (CL1477)
- Ask your physician to complete the Critical Illness Attending Physician's Statement (CL1476)

Please note that you are responsible for the cost of completing this form.

Critical Illness Claimant's Statement

This statement is to be completed by the Insured. If the Insured is unable to do so, provide the full name of the Claimant and relationship to the Insured on page 4.

FOR RETURN OF PREMIUM ON DEATH (ROPD), USE FORM CL213 CLAIMANT'S STATEMENT – LIFE INSURANCE CLAIM FORM

Insured's Information

Insured's Surname		First Name	
Policy Number		Date of Birth D D / M M / Y Y Y Y	Phone Numbers
Address			Home:
City	Province	Postal Code	Business:
Email			Cell:
Occupation			Last date worked D D / M M / Y Y Y Y

Details of Condition

1. Nature of illness or surgery: _____
2. Date symptoms first appeared: D D / M M / Y Y Y Y
3. Describe your symptoms: _____
4. Date you were advised of diagnosis: D D / M M / Y Y Y Y
5. Date of surgery if applicable: D D / M M / Y Y Y Y
6. On what date did you first consult a doctor for this condition? D D / M M / Y Y Y Y

   What is the name of the doctor you consulted? _____
7. Was this doctor your usual physician/family physician? ..... ○ Yes ○ No
8. What tests were conducted to diagnose your condition: _____
9. Have you previously suffered from, or received treatment for a similar or related condition? ..... ○ Yes ○ No

   If ***"Yes"***, give full details and dates for each episode: _____
10. Have any of your parents or siblings suffered from a similar or related illness? ..... ○ Yes ○ No

    If ***"Yes"***, state relationship, nature of illness and the age at which the illness was diagnosed: _____

Medical Consultations

1. Name of your family physician: _____ Phone Number: _____

   Address

   City Province Postal Code

2. Please give names, addresses and telephone numbers of all physicians who have treated you for this illness:

NAME(S) OF DOCTOR	ADDRESS (NUMBER, STREET, CITY, PROVINCE)	TELEPHONE	DATES SEEN
			D D / M M / Y Y Y Y
			D D / M M / Y Y Y Y
			D D / M M / Y Y Y Y

3. If you have been treated at a hospital or other medical facility, please provide details:

NAME(S) OF HOSPITAL	LOCATION (CITY)	DATE OF ADMISSION	DATE OF DISCHARGE
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y

4. Please describe other treatment you have received or are currently receiving for this condition:

TYPE(S) OF TREATMENT	WHERE	TREATING PHYSICIAN	DATES OF TREATMENT
			D D / M M / Y Y Y Y
			D D / M M / Y Y Y Y
			D D / M M / Y Y Y Y

Other

1. Are you covered for benefits from any other insurers for this condition? . . . . . ○ Yes ○ No

   If ***"Yes"***, provide details (incl. policy number(s)) and name(s) of other insurers: _____

2. Do you use any form of tobacco, nicotine products, or marijuana products? . . . . . ○ Yes ○ No

   If ***"Yes"***, describe the type, your daily consumption and state how long you have been using them: _____

   If ***"No"***, have you ever used any form of tobacco, nicotine or marijuana products? . . . . . ○ Yes ○ No

   If ***"Yes"***, when did you stop? Date stopped: D D / M M / Y Y Y Y

3. Please provide any other information you feel is important in support of your claim: _____

Authorization/Privacy Statement

Claimant's Certification: The above statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, the policy can be voided, payment of benefits denied and past claims payments recovered.

I hereby agree to refund to *ivari*, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim for benefits.

Privacy Notice: I understand that the information collected on this claim form, and otherwise in connection with my claim, is required by *ivari*, its reinsurers and authorized administrators (the "Insurer") for insurance purposes.

Examples of insurance purposes include: determining whether there is insurance coverage, investigating and administering claims, fraud detection and future business. For insurance purposes, the Insurer will consult its existing files, may collect additional information from and about me, including background checks, and, where required, exchange information about me with third parties. This collection, use and disclosure of personal information enables *ivari* to administer claim(s).

Your personal information may be used, stored or accessed in other countries and may be subject to the laws of those countries. Information may be disclosed in response to demands or requests from government authorities, courts, or law enforcement in these countries.

For more details about *ivari*'s Privacy Policy, please visit us at: **www.ivari.ca**.

A person may refuse to consent to this collection, use and disclosure of personal information. However, in that event *ivari* may be unable to provide claims services and this may result in delays in processing, or denial, of claim(s).

Insurer Authorization: I authorize the Insurer to collect, use and disclose personal information (including personal health information) about me for insurance purposes.

Authorization to Exchange Personal Information: I hereby authorize any person with relevant information about me, including but not limited to any physician or other health care provider, hospital or other health care institution or medically related facility, any insurance company or reinsurance company, employer or any governmental department, to release and exchange with *ivari*, or a representative thereof, all personal information (including personal health information, benefit payment or financial information), about me in its possession that is requested by *ivari* for insurance purposes.

This authorization does not have any expiry date and it will remain valid for as long as I am claiming eligibility for benefits or services from *ivari*. I, the undersigned, agree that a photocopy or electronic copy of this authorization as executed by me will be as valid as the original.

PLEASE PRINT IN INK.

Insured Name

Insured Signature

DD / MM / YYYY
Date

Claimant Name

Relationship to the Insured

Claimant Signature

DD / MM / YYYY
Date

500-5000 Yonge Street, Toronto, ON M2N 7J8 • Telephone: 1-800-846-5970 • Fax (416) 883-5715