500-5000 Yonge Street
Toronto, ON M2N 7J8
ivari.ca

*Critical*ADVANTAGE™ Claimant's Statement

PLEASE PRINT IN INK

If someone other than the claimant has completed this form or part of this form, please give full name and relationship to claimant:

Claimant's Surname: _____ First Name: _____

Policy Number: _____ Date of Birth: (DD/MM/YYYY) _____

Address: _____

Home phone: _____ Mobile phone: _____ Business phone: _____

Email: _____

Occupation: _____ Industry* _____

Last date worked: (DD/MM/YYYY) _____ On what date did symptoms begin? (DD/MM/YYYY) _____

Describe your symptoms: _____

On what date were you advised of the diagnosis? (DD/MM/YYYY) _____

If claiming for a **surgical procedure**, on what date did the surgery take place? (DD/MM/YYYY) _____

*For a list of valid industries refer to https://ivari.ca/tools-and-resources/administration/ and search for form number (IP-LP1971).

1 Please give dates and describe the onset and nature of your condition: _____

2 On what date did you first consult a doctor for this condition? (DD/MM/YYYY) _____

3 What is the name and address of the doctor? _____

4 Was this your usual medical attendant? ○ Yes ○ No

If ***"no,"*** who referred you to this doctor? _____

5 What tests were conducted to diagnose your condition? _____

6 What is your current treatment and on what date did it begin? _____

7 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: _____

8 Have any of your blood relatives suffered from a similar or related illness? ○ Yes ○ No

If ***"yes,"*** state relationship of relative, nature of illness and the age and year at which the illness was diagnosed:

9 Have you had any HIV Tests? ○ Yes ○ No

If ***"yes"***, please provide latest date: (DD/MM/YYYY) _____ Result: ○ positive ○ negative

If ***"no"***, has one been scheduled? ○ Yes ○ No

If ***"yes"***, please provide date: (DD/MM/YYYY) _____

10 a) Do you use nicotine products? ○ Yes ○ No

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

_____

b) If ***"no"***, have you ever used nicotine products, and if so what was your daily consumption and when did you stop?

_____

11 Please give names, addresses and telephone numbers of all physicians who have treated you or hospitals at which you have been treated for this condition.

NAME OF DOCTOR	ADDRESS (NUMBER, STREET, CITY, PROVINCE, POSTAL CODE)	TELEPHONE NO. INCLUDING AREA CODE	DATES SEEN (DD/MM/YYYY)

NAME OF HOSPITAL	ADDRESS (NUMBER, STREET, CITY, PROVINCE, POSTAL CODE)	TELEPHONE NO. INCLUDING AREA CODE	ADMISSION DATE (DD/MM/YYYY)	DISCHARGE DATE (DD/MM/YYYY)

12 If not already provided above, please give the name, address and phone number of your family physician in Canada:

_____

13 Are you insured for benefits related to this condition from another company? ○ Yes ○ No If ***"yes"***, please indicate:

NAME OF INSURER	POLICY NUMBER	TYPE OF BENEFIT	AMOUNT OF BENEFIT INSURED	HAS A CLAIM BEEN SUBMITTED?
			$	○ Yes ○ No
			$	○ Yes ○ No
			$	○ Yes ○ No

NOTICE OF DISCLOSURES

NOTICE REGARDING COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

The personal information provided in this form will form part of the file established and maintained at ivari's head office. The information in your file may be used for **the purposes of investigation and claim analysis**. ivari collects, uses and discloses your personal information as described in the sections of this form regarding the personal information authorization. In addition, we collect your personal information from this form, and any supplementary forms and questionnaires, and from the following **external sources**.

Physicians and other medical and health care practitioners and providers; hospitals, clinics and other medical facilities; other insurers and reinsurers; investigation agencies; motor vehicle and driver record authorities in any relevant jurisdictions; accountant(s); employer; workers compensation board or similar plan; any governmental departments; and your independent insurance advisors.

Personal information collected may include information about your health, character, general reputation, personal characteristics, finances, credit and lifestyle. A representative who is employed to collect information may contact you in person or by telephone in connection with this investigation. For more details about the claims analysis process, you may write to us at the **Claims Department**, ivari, 500-5000 Yonge Street, Toronto, Ontario M2N 7J8.

Your personal information may be shared with your independent insurance advisor and the managing general agencies, distributors and market intermediaries and their employees with which your advisor is associated for purposes identified above. If necessary, your personal information may also be shared with your beneficiaries in relation to a claim.

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

We have safeguards to protect your personal information; however, in the event of an unauthorized access, disclosure or use of your personal information, there is a possibility that you may experience: identity theft, negative effects on a credit record, financial loss, embarrassment or damage to reputation. If ivari believes that you face a real risk of significant harm, ivari's Privacy Office will notify you of the data breach and suggest steps to reduce your risk of harm.

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

You 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).

PERSONAL INFORMATION AUTHORIZATION

For the **purposes investigation and claim analysis**, I/we hereby authorize and direct any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance or reinsurance company, employer, workers compensation board or similar plan; any government department, or any other organization, institution, association or person identified in the Notices that now or may in the future have any information concerning me/us or my/our health, to disclose to ivari, its authorized representatives and its reinsurers, upon the request of ivari, any such information for the purposes identified in the Notices.

INSURER AUTHORIZATION

I/We authorize the Insurer to collect, use and disclose personal information (including personal health information) about me/us 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.

I understand that completion of this form does not constitute acceptance of the claim by ivari.

PRINT TO SIGN

Claimant's Signature

Date (DD/MM/YYYY)

500-5000 Yonge Street, Toronto, ON M2N 7J8 • Telephone: 1-800-846-5970

Print Form Clear Form