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

Critical Illness Claimant's Statement

Instructions to the Claimant/Insured: PLEASE PRINT IN INK

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. 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.

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 (DD/MM/YYYY)

Address

City | Province | Postal Code

Home phone | Mobile phone | Business phone

Email Address | Occupation | Industry* | Last date worked (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).

Details of Condition

1. Nature of illness or surgery: ____________________

2. Date symptoms first appeared: (DD/MM/YYYY) ____________
3. Describe your symptoms: ____________________

4. Date you were advised of diagnosis: (DD/MM/YYYY) ____________
5. Date of surgery if applicable: (DD/MM/YYYY) ____________
6. On what date did you first consult a doctor for this condition? (DD/MM/YYYY) ____________
   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 (DD/MM/YYYY)

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 (DD/MM/YYYY)	DATE OF DISCHARGE (DD/MM/YYYY)

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 (DD/MM/YYYY)

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: (DD/MM/YYYY) ____________

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

Declaration and Authorization

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.

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; 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 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.**

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

Authorization to exchange personal information: For the purposes of investigation and claim analysis, I/we, the Insured(s), hereby authorize and direct any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company 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.

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.

Insured name (please print)	Insured signature	Date (DD/MM/YYYY)
Claimant name (please print)	Claimant signature	Date (DD/MM/YYYY)

Relationship to the Insured

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

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