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

Insured's Request for Compassionate Assistance Benefit

A Policy details

INSURED

Policy number(s)	Policy Face Amount/Sum Insured(s) $

Name of Insured *(First, middle and last name)*	Date of birth (DD/MM/YYYY)
Address	Apt./Suite

City	Province	Postal code

Home phone	Mobile phone	Email address

POLICY OWNER IF OTHER THAN INSURED

Name of Insured *(First, middle and last name)*	Date of birth (DD/MM/YYYY)
Occupation	In what industry are you employed?*
Address	Apt./Suite

City	Province	Postal code

Home phone	Mobile phone	Business phone

Email address

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

B Benefit request details TO BE COMPLETED BY THE INSURED

Describe exact nature of your illness or injury:

Date you were first treated for your illness or injury? (DD/MM/YYYY) _____

Date of your most recent consultation with a medical professional regarding your illness or injury? (DD/MM/YYYY) _____

PRIOR ILLNESS OR INJURY:

a) Have you had the same kind of illness or injury before? ○ Yes ○ No

b) If ***"yes,"***

i) When? _____

_____

ii) By whom were you treated? _____

PROGNOSIS:

a) Has a medical professional diagnosed that your condition is terminal? ○ Yes ○ No

b) If ***"yes,"*** what life expectancy have you been given? _____

NAME AND ADDRESS OF YOUR DOCTOR(S): **PLEASE PROVIDE INFORMATION FOR ALL THE DOCTORS YOU HAVE SEEN IN THE PAST 5 YEARS**

1.	Name			Date of last visit (DD/MM/YYYY)
	Address			Telephone
	City	Province	Postal code	Fax
2.	Name			Date of last visit (DD/MM/YYYY)
	Address			Telephone
	City	Province	Postal code	Fax
3.	Name			Date of last visit (DD/MM/YYYY)
	Address			Telephone
	City	Province	Postal code	Fax

Most recent hospitalization (if applicable):

a) From: (DD/MM/YYYY) _____ to: (DD/MM/YYYY) _____

b) Name and address of hospital: _____

_____

_____

C Claim request

I request a one time only loan in accordance with the terms of the Compassionate Assistance Benefit Amendment.

Amount requested $_____ or maximum amount*_____

*Maximum amount = Total account value minus 3 monthly deductions/premiums.

D Privacy notice

"I" and "we" means the Insured and Owner(s) of the Policy.

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.

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.

By signing and submitting this form on your own behalf and/or on behalf of any minor, you give your consent to the collection, use and disclosure of your and/or the minor's personal information as described above and elsewhere in this form.

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 administration services and this may result in delays in processing, or denial, of requests.

E Declaration, acknowledgment and authorization

I/We hereby declare and agree that the statements and answers given above are true, complete and correctly recorded to the best of my/our knowledge and belief and are the basis for issuance of the attached Policy Amendment.

I/We agree and understand that any misrepresentation of information on this request form may make me/us liable to ivari for any payment made by ivari as a result of this request.

I/We acknowledge that receipt of a Compassionate Assistance Loan may, depending on all of the facts, be a taxable event with respect to which I/we am/are advised by ivari to consult a tax advisor for more details.

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: I/We hereby authorize any person with relevant information about me, including but not limited to any physician or other healthcare provider, hospital or other healthcare institution or medically related facility, any insurance company or reinsurance company, to release and exchange with ivari, or a representative thereof, all personal information (including personal health information, benefit payment), 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.

I/We, the Insured/Owner acknowledge that the Policy will be amended to include the Compassionate Assistance Benefit Amendment.

PRINT AND SIGN
Signature of Insured

Date: (DD/MM/YYYY) _____

Address:

PRINT AND SIGN
Signature of Witness

Date: (DD/MM/YYYY) _____

Address:

PRINT AND SIGN
Signature of Irrevocable Beneficiary

Date: (DD/MM/YYYY) _____

Address:

PRINT AND SIGN
Signature of Witness

Date: (DD/MM/YYYY) _____

Address:

PRINT AND SIGN
Signature of Owner (if other than Insured)

Date: (DD/MM/YYYY) _____

Address:

PRINT AND SIGN
Signature of Witness

Date: (DD/MM/YYYY) _____

Address:

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

Print Form Clear Form