CLEAR FORM

Disability Insurance Claim

1. Disability Insurance Claim

When should a Disability Insurance claim be made?

- If you are insured under: Disability Insurance or CIBC Payment Protector Insurance for CIBC Personal Loans; Disability Insurance for CIBC Personal Lines of Credit; CIBC Mortgage Disability Insurance or CIBC Mortgage Disability Insurance Plus; **and**
- You have suffered a Disability as defined in your Certificate of Insurance; **and**
- You have completed the mandatory wait period following the date of your Disability as defined in your Certificate of Insurance and you did not return to work before the next regular payment following the wait period.

What information is required for a Disability Insurance claim?

- The following sections of this claim form: **Claimant Statement, Employer Statement** and the **Attending Physician Statement**

How to find the account number?

- Sign on to CIBC Online or Mobile Banking and go to "My Accounts".
- View your statements.
- Contact your banking centre advisor.

Note: For Personal Lines of Credit, provide the 5-digit transit number and the 7-digit account number.

Where to submit the claim forms?

- **Email:** Call the Creditor Helpline at 1 800 465-6020 to set up secured email.
- **Mail:** CIBC Insurance, PO Box 3020, Mississauga STN A, Mississauga, ON L5A 4M2

Note: Any missing information may cause your claim to be delayed.

2. What happens after a Claim is submitted?

- You are responsible for your Loan, Personal Line of Credit (PLC) and Mortgage Loan payments and insurance premiums until the claim is approved; any payment eligible after satisfying your applicable wait period will be reimbursed;
- You will be advised if further information is required to process your claim;
- On approval of your claim, the Insurer will make your benefit payments to CIBC as long as you continue to qualify for benefits. A notice will be sent to you indicating the payment(s) made on your behalf and the date to which payment(s) may continue;
- If your claim is denied the Insurer will advise you in writing.

Do you need more information?

- Refer to your Certificate of Insurance for information about the terms, conditions, limitations, exclusions and other provisions of your coverage.
- **Call the Creditor Helpline at 1 800 465-6020.**

3. Your Privacy Matters - a note from the Insurer

- Creditor Insurance for CIBC Personal Loans, CIBC Personal Lines of Credit, CIBC Mortgage Disability Insurance and CIBC Mortgage Disability Insurance Plus are underwritten by **The Canada Life Assurance Company** ("Canada Life"). All plans are administered by CIBC and Canada Life, and are subject to certain terms, conditions, limitations and exclusions, which are set out in the Certificates of Insurance, which are provided upon enrolment. You may contact Canada Life at www.canadalife.com or 1 800 387-4495.
- When you requested coverage for your Personal Loan, Personal Line of Credit or Mortgage Loan, you gave the insurer personal information about yourself, which the insurer added to a client file. The purpose of this file, which is strictly confidential, is to allow the insurer and their reinsurers to conduct all the necessary business of insurance, including, setting fair premiums, receiving payments, assessing and paying claims, and keeping you informed of the status of your coverage. The insurer keeps client files at their head office or at another location authorized by the insurer.
- Only authorized personnel have access to personal information about you. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. If you want to know or correct any personal information in your claim file, just call the Creditor Helpline at 1 800 465-6020 and we will be happy to assist you.

  Protecting your personal information. At Canada Life (in this section " we" or "us"), we're committed to protecting personal information and respecting your privacy. Personal information is information that either on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

  How we use your personal information. Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to provide you with advice, evaluate your eligibility for products, price our products, collect feedback on our customer service, process claims and other financial transactions, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations.

Who we share personal information with. We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include our Canadian subsidiaries, and other organizations that provide us services such as paramedical examiners, medical laboratories, technology suppliers, other insurance or reinsurance companies, and your financial institution. As part of our day-to-day business, your personal information may be communicated to government departments and agencies, and may be communicated outside your province of residence or outside Canada. If there is a change of insurer your personal information will be disclosed to the subsequent insurer that provides the insurance. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

You're in control of your personal information. We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by submitting a request through our privacy centre at www.canadalife.com/privacy. This includes how you want to receive information from Canada Life using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights through our privacy centre such as access to or correction of your personal information.

If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

Want to learn more? Please visit www.canadalife.com/privacy.

4. Claimant Statement

Preferred language of correspondence ◯ English ◯ French

Information about Lending Product(s)

Please complete the information below for each lending product (Personal Loan, Personal Line of Credit, Mortgage Loan)
(Attach additional lending product(s) if more than 4.)

Lending Product 1 | Account Number | Lending Product 2 | Account Number

Lending Product 3 | Account Number | Lending Product 4 | Account Number

Information about the Banking Centre *(optional)*

Banking Centre Officer Name | Transit

Address | Branch Telephone Number Ext.

Information about Claimant

Title | First Name | Initial(s) | Last Name

Mailing Address *(Number and Street)*

City | Province/Territory | Postal Code

Telephone Number | Cell Number *(optional)* | Email Address *(optional)*

Date of Birth (Month day, year) | Gender | Occupation at date of Disability

Brief job description

Self-Employed ◯ Yes ◯ No | Employment Type (Full-time, Part-time, Contract, Seasonal, Temporary) | If seasonal, regular months of employment From: To:

Name of Employer at time of Disability

Address *(Number and Street)*

City | Province/Territory | Postal Code

Telephone Number Ext. | Start date of employment (Month day, year) | Last day worked (Month day, year) | Date or Expected date of return to work (Month day, year)

Are you currently receiving or will you become entitled to receive any benefits by reason of your disability from any of the following?
(Check all that apply)

☐ Workers' Compensation Board ☐ Employment Insurance ☐ Canada Pension Plan ☐ Quebec Pension Plan
☐ Other group insurance coverage *Provide company name and policy no.*
☐ Individual insurance coverage *Provide company name and policy no.*

4. Claimant Statement (continued)

Provide the name of the employer you worked for prior to taking your insurance along with the number of hours worked each week.

Name of employer

Address *(Number and Street)*

City | Province/Territory | Postal Code

Total hours worked each week

Cause of disability ◯ Illness ◯ Accident

If illness, date illness began (Month day, year)

If accident, date of accident (Month day, year)

Location of accident ◯ Work ◯ Elsewhere *(please specify)*

How did the accident happen? **If Motor Vehicle Accident, attach Police report**

Nature of illness or injury

Present treatment *(medication, diets, physiotherapy, etc.)*

Have you been hospitalized for this condition? ◯ Yes ◯ No

If Yes, provide length of stay and describe

Hospital Name

Hospital Telephone Number Ext.

Have you ever had the same or similar condition? ◯ Yes ◯ No

If Yes, please state when and describe

Name of current family physician

Physician Telephone Number Ext.

Mailing Address *(Number and Street)*

City | Province/Territory | Postal Code

Names and addresses of all the physicians who have treated you in the 24 months prior to becoming covered under this insurance

4. Claimant Statement (continued)

Claimant Authorization To Release Personal Information *(optional)*

If you wish to authorize someone other than yourself (such as a family member or friend) to communicate with The Canada Life Assurance Company (Canada Life) on your behalf with respect to your claim, please complete this Authorization Form. Communication will be limited to matters related to the claim for benefits. This authorization shall remain valid for the duration of the claim for benefits or until otherwise revoked by you. A reproduction of this authorization shall be as valid as the original.

I authorize Canada Life to communicate personal information that relates to my claim for benefits with:

Title | First Name | Initial(s) | Last Name

Mailing Address *(Number and Street)*

City | Province/Territory | Postal Code

Telephone Number | Cell Number *(optional)* | Email Address *(optional)*

Relationship

Please select one option (If no selection, medical information will not be released to the authorized appointed person.)

◯ Excluding medical information ◯ Including medical information

Signature and Authorization *(must be completed by the claimant)*

- I certify that the statements in this form are true and complete.
- I understand that The Canada Life Assurance Company will investigate my disability claim under Creditor Insurance for CIBC Personal Lines of Credit, CIBC Personal Loans, CIBC Mortgage Disability Insurance, or Mortgage Disability Insurance Plus.
- I understand that my personal information will be collected, used and shared as set out in the Privacy section and I authorize Canada Life, its agents and service providers to collect, use and exchange personal information about me (including all consultation and medical reports) needed by it for administration and adjudication of claims and by CIBC for the purpose of administering my claim under these Group Policies, with any person or organization who has relevant information pertaining to this claim, including health professionals, institutions, investigative agencies, insurers and reinsurers and administrators of government benefits and other benefits programs.
- For mortgage insurance claims: I authorize the use of my information collected in relation to this mortgage insurance claim for the purposes of reviewing and administering any other coverage I may have with respect to the insured mortgage.
- Canada Life may contact me using the contact information I have provided above, for the purposes of administering this claim.

A photocopy of this authorization is as valid as the original and shall continue to have effect throughout my claim.

Date (Month day, year) | Name of Claimant | **X** Signature (sign within box)

5. Employer Statement

To be completed by the Employer for whom you were working at commencement of disability. If unemployed at your date of disability, to be completed by the Employer for whom you last worked. If self-employed, to be completed by Claimant.

Information about Employer

Name of employer

Mailing address *(Number and Street)*

City | Province/Territory | Postal Code

Information about Claimant

Title | First Name | Initial(s) | Last Name

Occupation as of last day worked

Number of hours worked per week | Type of position (Full-time, Part-time, Contract, Seasonal, Temporary) | If seasonal, provide months of employment (inclusive) From: To:

Commencement date of employment (Month day, year) | Date last worked (Month day, year) | Date expected OR returned to work (Month day, year) | Return to work is/will be (Full-time, Part-time, Contract, Seasonal, Temporary)

Reason for discontinuing work

Brief outline of job duties and physical requirements (e.g.: amount of standing, bending, lifting, sitting, etc.). Please attach a copy of job description.

Has a claim been submitted to Workers Compensation? ◯ Yes ◯ No

If Yes, indicate the office address.

Name of insurance company (other than Worker's Compensation) providing group disability coverage for your employee/previous employee.

Contact Person | Policy Number

Telephone Number Ext.

5. Employer Statement (continued)

Information about Authorized Officer of the Employer

Title | First Name | Initial(s) | Last Name

Position

Telephone Number | Ext. | Fax Number | Ext. | Email

Signature and Authorization *(must be completed by the authorized officer for the employer)*

I certify that according to the records of this organization the above information is correct.

Date (Month day, year) | Name | X | Signature (sign within box)

Please return this form to your employee/previous employee.

6. Attending Physician Statement

Claimant to complete and sign Section 1 - Patient Information and Authorization below before requesting Section 2 - Physician Statement.

Section 1 - Patient Information and Authorization

Title | First Name | Initial(s) | Last Name

Date of Birth (Month day, year)

I authorize and direct any medical practitioner, hospital, or clinic or medically related facility, insurance company or other organization, institution or person that has, or may in the future have, any record pertaining to me or knowledge concerning me or my health to release and obtain any personal information about me (including all consultation and medical reports) to or from The Canada Life Assurance Company if my claim is for disability under Creditor Insurance for CIBC Personal Lines of Credit, CIBC Personal Loans, CIBC Mortgage Disability Insurance, or CIBC Mortgage Disability Insurance Plus for the purpose of the adjudication process or the evaluation of a claim, and CIBC as Administrator under the policies.

I understand that my personal information will be collected, used and shared as set out in the Privacy section and I authorize Canada Life, its agents and service providers to collect, use and exchange personal information about me (including all consultation and medical reports) needed by it for administration and adjudication of claims and by CIBC for the purpose of administering my claim under these Group Policies, with any person or organization who has relevant information pertaining to this claim, including health professionals, institutions, investigative agencies, insurers and reinsurers and administrators of government benefits and other benefits programs.

A photocopy of this authorization is as valid as the original and shall continue to have effect throughout my claim.

Date (Month day, year) | Name of the Patient | X | Signature of the Patient (sign within box)

Section 2 - Physician Statement

Note: Any charge for completing this form is the claimant's responsibility.

History

How long has Claimant been your patient? Years | Months

Date of diagnosis for the disabling condition (Month day, year)

Date patient became disabled (Month day, year)

Date of first visit within 12 months of the date of total disability (Month day, year)

Has patient ever had same or similar condition? ◯ Yes ◯ No ◯ Unknown

If Yes, state when and describe.

Is condition considered chronic? ◯ Yes ◯ No

Is condition due to injury or illness arising from patient's employment? ◯ Yes ◯ No ◯ Unknown

What precipitated absence from work?

Names and Addresses of Other Treating Physicians

1. Title | First Name | Initial(s) | Last Name

Address *(Number and Street)*

City | Province/Territory | Postal Code | Telephone Number Ext.

Specialty | Fax Number Ext.

2. Title | First Name | Initial(s) | Last Name

Address *(Number and Street)*

City | Province/Territory | Postal Code | Telephone Number Ext.

Specialty | Fax Number Ext.

6. Attending Physician Statement (continued)

Section 2 - Physician Statement (continued)

Cause of Disability

Primary Diagnosis *(including any complications)*

Secondary Diagnosis *(if applicable)*

Additional conditions or complications which might affect duration of absence from work

Subjective symptoms

Objective signs *(including results of current x-rays, EKG'S, MRI'S, CATSCANS or laboratory data and any relevant clinical findings). Please provide copies.*

Is the patient receiving or in need of treatment for the use of alcohol or drugs? ◯ Yes ◯ No

If yes, please advise all details of the rehabilitation program.

If relevant, blood pressure at time of latest attendance

Current Functional Limitations

Function	Degree of limitation				
Cognition	◯ None	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know
Speaking	◯ None	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know
Hearing	◯ None	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know
Sensation	◯ None	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know
Psychological	◯ None	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know
Driving	◯ None	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know
Walking	◯ None	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know
Standing	◯ None	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know
Climbing	◯ None	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know
Sitting	◯ None	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know
Bending	◯ None	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know
Lifting	◯ None	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know
Dexterity	◯ None	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know
Vision	◯ None	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know

Please add any other functions limited by the illness or injury:

_____	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know
_____	◯ Slight	◯ Moderate	◯ Severe	◯ Don't Know

Please indicate maximum recommended weight

Pounds or Kilograms

6. Attending Physician Statement (continued)

Section 2 - Physician Statement (continued)

Describe any functional limitations, physical or psychological, which you consider to be major obstacles to the person's ability to work.

Were any functional capacity evaluations performed? ◯ Yes ◯ No

If yes, state when and type

Treatment

Date of first visit for the disabling condition (Month day, year)

Date of latest visit for the disabling condition (Month day, year)

Frequency of visits ◯ Weekly ◯ Monthly ◯ Other *(Specify)*

Nature of treatment *(including surgery, physiotherapy and medications prescribed, if any)*

To your knowledge is patient following recommended treatment program? ◯ Yes ◯ No

If No, please comment

Progress

Has patient ◯ Recovered ◯ Improved ◯ Not Improved ◯ Retrogressed

Please comment

Prognosis

Is patient now totally disabled from own occupation? ◯ Yes ◯ No

If Yes, state date you think patient will be able to resume work (Month day, year)

If No, state date patient was able to work (Month day, year)

If return to work date is unknown, estimate

Is patient a suitable candidate for some trial employment or rehabilitation? ◯ Yes ◯ No

If Yes, state date (Month day, year)

If patient is pregnant, please indicate estimated date of delivery (Month day, year)

6. Attending Physician Statement (continued)

Section 2 - Physician Statement (continued)

Information about Referrals

Has patient been referred to another doctor? ◯ Yes ◯ No

If Yes, date referred (Month day, year)

Title | First Name | Initial(s) | Last Name

Mailing Address *(Number and Street)*

City | Province/Territory | Postal Code

Telephone Number | Ext. | Fax Number | Ext.

Specialty

Information about Attending Physician

Title | First Name | Initial(s) | Last Name

Name of Facility *(Hospital, Medical Center)*

Mailing Address *(Number and Street)*

City | Province/Territory | Postal Code

Telephone Number | Ext. | Fax Number | Ext.

Specialty

By signing here, you acknowledge that the answers given above are true and complete to the best of your knowledge.

Date (Month day, year) | Name | X | Signature (sign within box)

Please return this form to your patient.

The patient is responsible for securing this form and for any charges made for its completion.