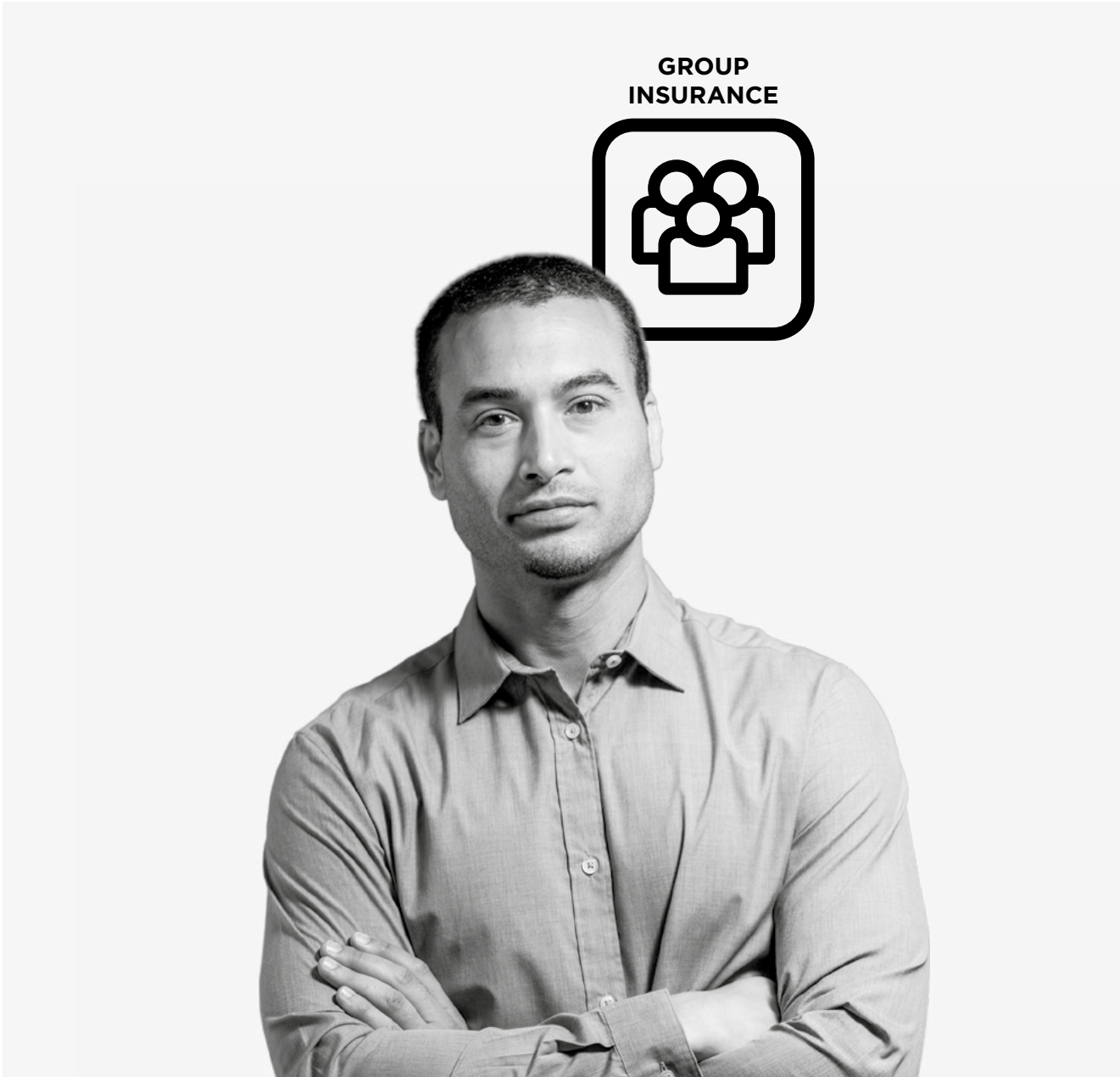


**GROUP  
INSURANCE**



F54-856A(17-03)

# **Critical Illness Claim Form**



**INVESTED IN YOU.**

iA Financial Group is a business name and trademark of  
**Industrial Alliance Insurance and Financial Services Inc.**

**ia.ca**

According to your region, please submit the completed form to:

**Quebec**  
PO Box 790, Station B  
Montreal, Quebec H3B 3K6

**Ontario and Atlantic Provinces**  
522 University Avenue, Suite 400  
Toronto, Ontario M5G 1Y7

**POLICYHOLDER'S STATEMENT**

PLEASE PRINT. TO SPEED UP PROCESSING, ANSWER ALL QUESTIONS.

Policyholder's name \_\_\_\_\_

Address \_\_\_\_\_ Postal code 

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Telephone 

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 Email \_\_\_\_\_

Authorized person's name \_\_\_\_\_

**PART 1 – MEMBER INFORMATION**

1. Member's name \_\_\_\_\_

2. Policy no. 

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 Division no. 

--	--	--	--

 Class no. 

--	--	--	--

 Certificate no. 

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3. Occupation \_\_\_\_\_

4. Date hired 


 Certificate effective date 


Last day at work 


 Amount of coverage \$ \_\_\_\_\_

5. Please indicate any other comments relevant to this claim.  
\_\_\_\_\_  
\_\_\_\_\_

I certify the accuracy of the information above.

Authorized signature **X** \_\_\_\_\_ 


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**CLAIMANT'S STATEMENT**

TO SPEED UP PROCESSING, PLEASE ANSWER ALL QUESTIONS AND OBTAIN ALL REQUIRED SIGNATURES.

**IDENTIFICATION**

Claimant's name (if different from plan member) \_\_\_\_\_

Date of birth 

Y	M	D
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Plan member's name \_\_\_\_\_

Certificate no. \_\_\_\_\_ Date of birth 

Y	M	D
---	---	---

Address \_\_\_\_\_

Postal code 

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 Telephone 

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Employer's name \_\_\_\_\_

Date hired 

Y	M	D
---	---	---

 Date of onset illness 

Y	M	D
---	---	---

 Date of surgery 

Y	M	D
---	---	---

**CLAIMS AND RELATED DETAILS**

1. Please indicate the type of critical illness that you are claiming.  
\_\_\_\_\_
2. Please give full details of the extent and nature of your illness.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Have you previously suffered from, or received treatment for, the same or a similar or related illness?  
No  Yes  If "yes," give full details.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. On what date did you first consult a doctor in connection with your illness?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Please give details of the treatment you received including details and dates of any hospital investigations or in-patient treatment.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CLAIMS AND RELATED DETAILS (CONTINUED)**

6. Have any of your blood relatives suffered from a similar or related illness? If "yes," state relationship of relative, nature of illness and the date when the illness was diagnosed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Please provide names, addresses and telephone numbers of all physicians who have treated you or hospitals at which you have been treated for this illness (include dates attended).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Please provide the name, address and phone number of your family physician.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CONFIRMATION and AUTHORIZATION OF PLAN MEMBER AND CLAIMANT (if different)**

**I HEREBY CONFIRM** that the information contained in this Claim form for a Critical Illness Benefit is true and complete to the best of my knowledge.

If this claim is being made on behalf of my spouse or dependent child, **I CONFIRM that I am AUTHORIZED** to disclose information about them with respect to the claim.

On behalf of myself and my dependents:

**(1) I consent to the RELEASE** of the information contained in this Claim form to Industrial Alliance Insurance and Financial Services Inc. (the "Company"), its employees, agents, reinsurers and service providers for the purpose of underwriting, administration and processing of the claim; and

**I UNDERSTAND AND AUTHORIZE** that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, the Company will have the right to use and exchange any information related to the claim with any relevant regulatory, investigative or government body, any healthcare provider or professional medical organization, insurance company or reinsurer, the policyholder, my employer or any other party as provided by law for the purpose of investigating any such fraud or abuse.

**I UNDERSTAND** that personal information may be subject to disclosure to those authorized under the applicable laws within or outside of Canada.

**(2) I AUTHORIZE** any healthcare provider or professional, medical organization, insurance or reinsurance company, workers' compensation board, the policyholder, my employer, as well as any other person, public or private organization or institution to disclose to the Company, its employees, agents and service providers any information which they may need in the assessment of the claim.

**I AUTHORIZE** the use of my Social Insurance Number as an identification number where it is required for the administration of the group policy.

**I AGREE** that a photocopy of this Confirmation/Authorization shall be as valid as the original. I understand that by furnishing this form and investigating the claim or accepting proofs of the claim, the Company shall not be held to admit the validity of the claim nor to have waived any of its rights in defence of the claim arising under the Group Policy.

Signature of plan member (mandatory) **X** \_\_\_\_\_

Y M D  
| | | | | | | | | |

Signature of claimant (if different) **X** \_\_\_\_\_

Y M D  
| | | | | | | | | |

**LIMITATION PERIOD NOTICE**

We are required under certain legislation to advise you that your claim under your group policy is governed by a limitation period that is set out in the *Insurance Act* or other applicable legislation in your province (e.g. *Limitations Act, 2002* (Ontario), *Civil Code* (Quebec)). This means you cannot sue after a certain period of time has passed. You must obtain your own independent advice in regard to this limitation period.

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**Quebec** PO Box 790, Station B Montreal, Quebec H3B 3K6  
**Ontario and Atlantic Provinces** 522 University Avenue, Suite 400 Toronto, Ontario M5G 1Y7

**MEMBER IDENTIFICATION** (The member must complete this section)

Last name \_\_\_\_\_ First name \_\_\_\_\_  
Policy no. [ ][ ][ ][ ][ ][ ] Social Insurance Number [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] Certificate no. [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]  
Date of birth [ ][ ][ ][ ][ ][ ][ ] Y M D

**ATTENDING PHYSICIAN'S STATEMENT**  
Please print and give to the patient  
**PLEASE ANSWER ALL QUESTIONS AND ATTACH ANY DOCUMENTS PERTINENT TO THE ANALYSIS OF THE REQUEST**

**PART 1 – DIAGNOSIS**

Patient last and first name \_\_\_\_\_ Date of diagnosis [ ][ ][ ][ ][ ][ ] Y M D  
1. Primary \_\_\_\_\_  
2. Secondary \_\_\_\_\_  
3. The patient is a: Smoker  Non-Smoker   
4. For the illnesses or associated symptoms diagnosed, has the patient previously:  
received medical treatments  consulted another physician  taken medication  been hospitalized   
undergone examinations  Specify the periods: \_\_\_\_\_

**PART 2 – TREATMENT**

1. Medication (name and dosage): \_\_\_\_\_  
2. Has the patient undergone or will the patient undergo:  
a) Examinations or tests No  Yes  Specify and provide copies of test results: \_\_\_\_\_  
b) Surgery No  Yes  Day surgery  Type: \_\_\_\_\_ Date: [ ][ ][ ][ ][ ][ ] Y M D  
Surgical procedure: \_\_\_\_\_  
c) Other treatments? No  Yes  Specify: \_\_\_\_\_  
d) Hospitalization From [ ][ ][ ][ ][ ][ ] Y M D to [ ][ ][ ][ ][ ][ ] Y M D  
Name of hospital: \_\_\_\_\_  
e) A short stay under observation (number of hours): \_\_\_\_\_

**PART 3 – FOLLOW-UP AND PROGNOSIS**

1. Date of first consultation for this illness: [ ][ ][ ][ ][ ][ ] Y M D  
Next consultation: [ ][ ][ ][ ][ ][ ] Y M D Starting date of illness: [ ][ ][ ][ ][ ][ ] Y M D  
2. Dates of other consultations: [ ][ ][ ][ ][ ][ ] Y M D Follow-up frequency: \_\_\_\_\_  
3. Referral to another physician: No  Yes  Name of physician: \_\_\_\_\_  
Specialty: \_\_\_\_\_

**PART 4 – IDENTIFICATION OF THE ATTENDING PHYSICIAN**

1. Last and first name \_\_\_\_\_ Telephone [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]  
2. Address \_\_\_\_\_ Fax [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]  
3. General practitioner  Specialist  Other  Specify: \_\_\_\_\_  
Signature X \_\_\_\_\_ [ ][ ][ ][ ][ ][ ] Y M D

**NOTE: THE MEMBER IS RESPONSIBLE FOR ANY FEES CHARGED TO COMPLETE THIS FORM.**