

Before submitting your claim:

- Before you submit your claim, you may wish to review your Critical Illness coverage* to ensure that the condition you wish to claim for is a condition covered by your policy.
 - You may also wish to review the other terms and conditions of your Critical Illness coverage*, such as whether your policy contains a waiting period, limitations and/or exclusions.
- * The document which describes your coverage may be called an Insurance Certificate or a Summary of Insurance.

To ensure your claim is processed promptly:

- You will find enclosed claim forms that you, your physician and your employer* will need to complete, sign and return to us in order to apply for Critical Illness benefits. Please ensure that the forms have been fully completed before returning it to our office. ***The Certificate of Employer form is only required if your Critical Illness coverage is provided through your employer.**
- A Doctor of Medicine must complete the Attending Physician's Statement. As our Medical Directors do not examine you, we depend on the quality of the medical information given by your physicians to assess your claim. Please ensure that your physician includes copies of all specialist consultation, investigation and test results which confirm your diagnosis. The medical information we require is listed on the Attending Physician Statement.
- To avoid unnecessary delays, please be sure to include your policy number and policyholder name.
- We have included an authorization in addition to the claim form. By signing this authorization and declaration, you give Industrial Alliance Insurance and Financial Services Inc. consent to obtain information from your physicians, your employer, other insurers and health care providers and others as described in the Authorization. We will need your permission to obtain the necessary information to assess your claim.
- Submit all forms together to Industrial Alliance at the address below. You may also send your claim form and authorization the fax number below. If you send your claim form by fax, please also mail the original form and authorization.
- We recommend you keep a photocopy of the completed forms and authorization for your records.
- We recommend that you submit your claim as soon as possible as there may be a time limitation on your policy.

Upon receipt of your claim:

- Once we receive your claim forms, we will send you a letter to acknowledge receipt of your claim within five (5) business days.
- We will assess your claim to determine your eligibility for benefit in accordance with the terms and conditions of your Policy.
- During the assessment of your claim, we will need to request additional information from your doctors and/or from the provincial health records, or other sources. It normally takes a few weeks to receive this information. If it takes longer than a few weeks, we will be in touch with you to see if you can help us get this information.
- **Once all of the necessary information to determine your eligibility for benefits has been received, we will notify you of our decision.**

Important notes and answers to some frequently asked questions:

- We will keep you up to date on the status of your claim as outlined above.
- You are responsible for any costs associated with providing the initial proof of claim, including the cost of medical information provided by your attending physician(s). When Industrial Alliance requests information directly from your physician(s), we will offer to pay a correspondence fee for it.
- You should feel free to call us if you have any questions about your claim or the claims process. Your adjuster will be pleased to answer your questions.
- If you are unable to reach your adjuster immediately, please leave a message. We strive to return all calls within one business day.

You can contact us at:

**Industrial Alliance
Insurance and Financial Services Inc.**
Life and Health Claims Department
Special Markets Solutions
2165 Broadway W, PO Box 5900
Vancouver, BC V6B 5H6

Toll Free Telephone: 1-800-266-5667
Fax: (604) 733-9519

Please print in ink

POLICY INFORMATION			
Policy Number 100005769	Policyholder Name Catholic Independent Schools of Vancouver Archdiocese (CISVA)	Original effective date of coverage	
<input type="checkbox"/> Individual Insurance		<input type="checkbox"/> Creditor Insurance	
<input checked="" type="checkbox"/> Group Insurance			
IDENTIFICATION AND CONTACT INFORMATION			
First Name	Last Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address			
Number	Street	Unit/Suite/Apt. No.	
City	Province	Postal Code	
Home Telephone Area code	Cellular Phone Area code	Work Telephone Area code	
Email			
Date of Birth		Provincial Health Number	
Occupation		Employer Name	
Date Hired	Last Day worked	Return to work or expected return to work date	
INFORMATION ABOUT YOUR HEALTH			
Describe the Type of Critical Illness or Type of Surgery		Date of diagnosis or surgery	
Date first symptoms began	Description of first symptoms		
Date of first medical visit for this condition	First doctor, hospital, and/or clinic seen:		
	Name of physician or clinic	Telephone Number	Address
Did you have investigations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate where the investigations took place			
Name of physician or clinic	Telephone Number	Address	
Name of physician who made diagnosis			

Names of all other physicians, specialists, clinics and hospitals seen for your condition		
Name of physician or clinic	Telephone Number	Address

What treatment have you received or will you be receiving for this condition

Have you had the same, similar or related condition in the past? Yes No
 If yes, please provide details & dates

Do you smoke or use tobacco products?

<input type="checkbox"/> Yes Please indicate the amount per day: _____ How long have you used tobacco? _____	<input type="checkbox"/> No Have you used tobacco products in the past? <input type="checkbox"/> Yes, what date did you quit? _____ <input type="checkbox"/> No
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Has any blood relative suffered from a similar or related illness? Yes No
 If yes, please indicate

Relationship	Nature of Illness	Age at which Illness was diagnosed
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PHYSICIAN AND HOSPITAL INFORMATION

Name of your primary personal physician/ family physician / primary medical clinic	How long have you been with this physician and/or clinic?
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If you have been with your primary physician /family physician / primary medical clinic you indicated above for less than 5 years, please list all physicians, medical clinics or hospitals seen in the last 5 years

Name of physician or clinic	Telephone Number	Address
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Please provide any further information which you think might be helpful in support of your claim

I hereby certify that all the information contained in this declaration is accurate and complete and that any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as the result of this claim.

Signature	Date
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PROTECTING THE PRIVACY OF YOUR PERSONAL INFORMATION

At Industrial Alliance Insurance and Financial Services Inc., we recognize and respect every individual's right to privacy. Personal information about you is kept in a confidential claim file at the offices of INDUSTRIAL ALLIANCE or of an organization authorized by Industrial Alliance in a secure area. We limit access to information in your files to Industrial Alliance staff or persons authorized by Industrial Alliance who require this access to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

We use this information to investigate, assess and administer your claim and the terms of the Insurance contract provisions.

You may access the personal information contained in your file and correct any inaccurate information. Any personal health information will be provided to you through a medical practitioner of your choice. To view your personal information please send a request in writing to the attention of the Claims Department at the above address, together with the name of the Medical practitioner.

AUTHORIZATION AND DECLARATION

I hereby authorize Industrial Alliance Insurance and Financial Services Inc., for the purposes of investigation, evaluation and administration of my claim:

a) to gather only the information necessary for the above specified purposes from any person or organization that has personal information relating to me, including other insurers, reinsurers, and financial institutions; physicians, medical institutions and healthcare providers; employers or administrators of group benefits; agents or brokers; investigating and credit reporting agencies, and all persons or organizations likely to have personal information relevant to my claim.

b) to disclose and exchange only the necessary personal information Industrial Alliance has relating to me to the above persons and organizations.

I understand that the personal information obtained by the use of this authorization will be used by Industrial Alliance in the investigation, administration and evaluation of a claim for benefits. Any information obtained will not be released by Industrial Alliance, except to persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I confirm that a photocopy or electronic copy of this authorization shall be valid as the original.

I declare that the information provided in the Claimant's Statement is accurate and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as the result of this claim.

Claimant's Name (Please Print): _____

Signature of Claimant: _____ Date: _____
(dd/mmm/yyyy)

Part 1 – Patient to complete this authorization

This is not a request for examination but for information taken from your chart. The patient is responsible for securing this form and any charges for its completion.

Patient Name	Date of Birth
	Policy Number

I hereby authorize the release of any information requested on this form to the Industrial Alliance Insurance and Financial Services Inc. or any of its agents.

Patient Signature Date DD/MMM/YYYY

Please print in ink

Part 2 – Physician to complete this

Diagnosis	Date diagnosis confirmed
Date of onset of first symptoms	Description of first symptoms
Date of first medical visit related to this condition	Location of first medical visit (family doctor, emergency room, walk-in clinic etc.)

In order to assist us in promptly assessing your patient's claim, **please include copies of relevant consultation reports, investigation and test results which confirm the diagnosis**, including:

For Cancer	For Heart Attack	For all other conditions
<ul style="list-style-type: none"> ✓ Pathology reports ✓ Specialist consultation reports ✓ All other relevant reports detailing <ul style="list-style-type: none"> Site of Tumor Type of Tumor Size of Tumor Depth of Tumor Histology Staging Adjacent tissue invasion Lymph node involvement Metastases 	<ul style="list-style-type: none"> ✓ Specialist Consultation reports ✓ Echocardiograms ✓ Laboratory test results, including cardiac biochemical markers, cardiac enzymes ✓ Operative reports ✓ Angiographic, Echocardiogram studies 	<ul style="list-style-type: none"> ✓ Specialist Consultation reports ✓ Operative reports ✓ CT Scans, MRI, X-Rays, etc. ✓ Angiographic, Echocardiogram, Electrocardiograms studies ✓ Laboratory test results ✓ Neurological assessments ✓ All other relevant reports confirming diagnosis

Did your patient attend the Hospital Emergency? Yes No Was your patient Hospitalized? Yes No

Please attach a copy of the Discharge Summary. If not available then please indicate:

Name of Institution	Date of admission	Date of discharge
Surgery performed or planned? <input type="checkbox"/> Yes <input type="checkbox"/> No	Procedure	Date
Name Surgeon	Specialty (if applicable)	

Current and planned treatment		
Has the patient ever had the same or similar Condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, please provide date, diagnosis, and treatment received:		
Family physician's name		
Date patient was first under your care	If patient was referred to you, name the referring physician	Date Referred
Names and specialties of other physicians who are or will be involved in your patient's care		
Physician Name	Specialty	Date of consultation
Have any of your patient's blood relatives suffered from the same, a similar or related illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, please indicate:		
Relationship	Nature of Illness	Age at which Illness was first Diagnosed
Does your patient currently use tobacco or a tobacco substitute? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Has your patient ever used tobacco or a tobacco substitute? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, please indicate date stopped		
Any other comments		

Physician Name	Specialty	Phone
Address		Fax
Physician's Signature, M.D.		Date