



Claims Cover Sheet

To: **Unity Managing Underwriting**

Claims Email Hotline: lbipclaims@cashcanada.com

Date: _____ (dd/mm/yy)

No. of Pages: _____ (incl. cover)

Store Number: _____

Contact: _____

Store Email: _____

Store Phone: _____

Claimant's Name: _____

Claim Checklist

Check boxes for completion:

| | |
|---|--------------------------|
| Claims Checklist Included ? | <input type="checkbox"/> |
| Claim Form completed in full ? (Doctor/Employer's section completed) | <input type="checkbox"/> |
| Copy of loan documents attached ? | <input type="checkbox"/> |
| Additional Information ? <i>(please note)</i> | <input type="checkbox"/> |

ONCE FAXED, PLEASE ENSURE ALL CLAIM DOCUMENTS ARE STORED IN THE CUSTOMER'S FILE!



Injury/Fracture/Sickness Claim

Payroll Loan Balance Insurance Plan PRL722

ACE INA Life Insurance
PO Box 1097, Station B, Willowdale, ON, M2K 3A2
Toll-free 1-888-561-1101
Fax to 416-221-1685

LENDER SECTION ONLY

Lender's Name: _____ Br #. _____
Contact Name: _____
Branch Phone #: _____
Branch Fax #: _____
Branch _____
Authorization: _____
Branch Signature _____

TO AVOID DELAYS IN ASSESSING YOUR CLAIM

Note: There are 3 parts to this form.

- You (the Insured/Claimant) must fully complete and sign Section 1 of this page and attach your Loan Documents;
- Have Section 2 completed and signed by the Employer; **only if you were unable to work for 5 consecutive days due to Injury or Sickness;**
- Section 3 **must be completed and signed by your Physician** who has your medical records. If you have no family Physician then by the Physician who treated your Injury or Sickness;
- Mail/Fax all 3 Sections of this form to the insurer at the address shown above.

SECTION 1 - CLAIMANT'S STATEMENT

(To be completed by the Insured/Claimant - Please print clearly)

Reason for Claim: Injury/Fracture Sickness

Information about Insured/Claimant

Name _____
(Last) _____ (First) _____ (Init) _____

Address _____
(number, street, apartment number) _____ (city) _____ (province) _____ (postal code) _____

Telephone No. () _____ Sex M F Date of Birth (mm/dd/yyyy) _____

Name of your Employer At Time of Loss _____

Information about your Injury/Sickness; (For Injury or Fracture or for Sickness Complete Below)

A) Date of Accident/Sickness occurred (mm/dd/yyyy) _____ Place of Accident: _____

Describe fully how the accident occurred: _____

Describe your injury/Sickness _____

Name of your employer: _____

SECTION 2 - EMPLOYER'S STATEMENT

Note to Claimant:

- To be completed by your Employer only if you are unable to work for 5 consecutive days due to Injury or Sickness.
- However you are not required to have this Section (2) completed if you were hospitalised for more than 24 hours due to Injury.

(Please Print Clearly)

Employee's Name _____ Date of Birth (mm/dd/yyyy) _____
(Last) _____ (First) _____ (Init) _____

Reason For Employee's Absence From Work _____

Employee's Last Day Worked _____ On what date did or will the employee return to work? _____
(mm/dd/yyyy) _____ (mm/dd/yyyy) _____

Employer's Name _____ Employer's Fax Number _____

Employer's Address _____
(number, street, apartment number) _____ (city) _____ (province) _____ (postal code) _____

Name of Authorized Official _____ Print Title of Authorized Official _____

Signature _____ Date Signed _____

Claimant's Certification: The above statements are true and complete to the best of my knowledge and belief.

Privacy Notice : The information provided on this claim form and otherwise in respect of this claim, is required by ACE INA Life Insurance, its reinsurers and authorized administrators (the "Insurer") to assess this claim. For these purposes, the Insurer will also consult its existing insurance files, collect additional information from the claimant and where required, collect information from and exchange information with, third parties. Limited information related to the status of the claim and the amount of the debt will be exchanged with the creditor who is the beneficiary under this plan, strictly for the purpose of administering insurance benefits. Medical information or details relating to the claimant's employment will not be provided to the creditor without an additional specific authorization to that effect.

Authorization : I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any employer, physician, practitioner, health care professional, hospital, health care institution, and any other medical or medically related facility, any insurance or reinsurance company, Workers' Compensation Board or similar plan or organization, federal, territorial or provincial government department, or any other corporation or organization, institution or association, possessing records or knowledge of me to release and exchange with ACE INA Life Insurance, or representatives thereof, all personal health information, benefit payment, employment or financial information about me or in its possession that is requested while administering this claim. A photocopy of facsimile of this authorization is as valid as the original.

I understand why I have been asked to disclose this information and the risks and benefits of consenting or refusing to consent. I understand that I can withdraw my consent at any time, but that if I do, the Insurer will not be able to assess my claim and will not pay benefits

Claimant's Name _____ Signature _____ Date _____



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SECTION 3 - PHYSICIAN'S STATEMENT

Note to Claimant:

- To be completed by the family physician who has the medical records. If there is no family physician, then by the physician treating the current injury or sickness.

The Claimant/Patient is responsible for having this form completed and for any fees charged.

(Please Print Clearly)

Patient's Name (Print) _____ Date of Birth (mm/dd/yyyy) _____

HISTORY

- A) When did symptoms first appear or accident happen? (mm/dd/yyyy) _____
- B) Has patient ever had the same or a similar condition? Yes (State When and Describe below) _____ No Unknown
- C) Is condition due to accident or sickness arising out of employment? Yes No Unknown
- D) Name of any other treating physicians: _____
 Address _____
(number, street, apartment number) (city) (province) (postal code)

DIAGNOSIS (including any complications)

- A) Primary Diagnosis _____ Date of Diagnosis: _____
(mm/dd/yyyy)
- B) Secondary (if applicable) _____ Date of Diagnosis: _____
(mm/dd/yyyy)
- C) Subjective Symptoms _____
- D) Objective Findings _____
(x-rays, laboratory, EKG, clinical findings)
- E) List below any bones that were fractured: _____

TREATMENT

- A) Date of First Visit (mm/dd/yyyy) _____ Date of Last Visit (mm/dd/yyyy) _____
- B) Frequency of visits weekly monthly Other specify _____
- C) Date of Hospitalization: Confined from (mm/dd/yyyy) _____ to (mm/dd/yyyy) _____
- D) Nature of Treatment _____
- E) Does the fracture indicated above require the following treatment(s):
 Fixation Metal fixation Open operation grafting _____ Date of Treatment (mm/dd/yyyy) _____

REMARKS

Period during which patient was unable to work: From _____ To _____
(mm/dd/yyyy) (mm/dd/yyyy)

Additional comments/information _____

Name of Attending Physician _____ Telephone () _____
(print)

Address _____
(number, street, apartment number) (city) (province) (postal code)

Physician's Signature _____ Date Signed _____



IMPORTANT!!!

Thank you for completing your application for coverage. Should your claim for benefits be successful you will be eligible for benefit payments equal to the following:

| Time Frame | What is Required to Receive Benefit | Benefit Amount |
|--|-------------------------------------|---|
| After you have missed 5 consecutive days of work | Completed claims Package | 50% of the outstanding balance due on the date you were injured/ill |

Please bring/fax/email confirmation to your Cash Canada branch for processing.

DECLINED

If your claim for benefits is declined, you will be contacted by both your Cash Canada store by phone, and ACE Life assurance in writing.

You will be required to pay all outstanding payments within three business days of the date the claim was denied, to avoid any late fees. **If payment is not made within the three days grace period your account will be subject to all regular penalties and late fees.**

Should you wish to dispute any decision made by the insurer you may contact your Cash Canada store, or ACE directly at 1.877.319.7151.