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**CRITICAL ILLNESS**  
**Proof of Claim - Claimant's Statement**

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Policy Number: \_\_\_\_\_

**PERSONAL DETAILS**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone Res: ( ) \_\_\_\_ - \_\_\_\_  
\_\_\_\_\_ Other: ( ) \_\_\_\_ - \_\_\_\_  
\_\_\_\_\_ Postal Code

**CLAIM AND RELATED DETAILS**

Name of illness for which you are claiming: \_\_\_\_\_

Please describe the nature and extent of the illness for which you are claiming:

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On what date was your condition diagnosed or surgery performed? \_\_\_\_\_

On what date did symptoms first commence? \_\_\_\_\_

Please describe these symptoms: \_\_\_\_\_

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On what date did you first consult a medical practitioner in connection with your illness?

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Please indicate the name and address of the Physician seen: \_\_\_\_\_

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Have you undergone any tests or investigations related to the diagnosis? If yes, please provide details and dates.

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Have you previously suffered from, or received treatment for, a similar or related illness? If yes, please give details including dates.

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**MEDICAL CONSULTATIONS**

Please provide the Name and Address of your personal physician.

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Please provide details of any other doctors or specialists who have been consulted in connection with your illness:

Name Address Dates Seen

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If you have been treated at a hospital or similar institution please supply the following information:

Name of Hospital City or Province Date of Admission Date of Discharge

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What other treatment have you received and are you currently receiving in connection with your illness?

Type of Treatment Institution / Prescribing Physician Dates

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**GENERAL**

Has any blood relative suffered from a similar or related illness? If yes, please indicate:

Relationship Nature of Illness Age at which Illness was first Diagnosed

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Are you insured for benefits related to this illness with another company? If yes, please indicate:

Name of Insurer Type of Benefit Amount of Benefit Insured Has a Claim been Submitted?

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Do you smoke or use tobacco products? Yes  No

If YES, please indicate amount per day: \_\_\_\_\_ How long have you used tobacco? \_\_\_\_\_

If NO, did you previously use tobacco products? Yes  No

On what date did you quit? \_\_\_\_\_

Please provide any further information which you think might be helpful in support of your claim.

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## Protecting the Privacy of Your Personal Information

At Industrial-Alliance *Pacific* Life Insurance ("IAP") 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 IAP or of an organization authorized by IAP in a secure area. We limit access to information in your files to IAP staff or persons authorized by IAP 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 Declarations

I hereby authorize Industrial-Alliance *Pacific* Life Insurance Company 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 IAP 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 IAP in the investigation, administration and evaluation of a claim for benefits. Any information obtained will not be released by IAP, 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 Signature

\_\_\_\_\_  
Claimant's Name (Please Print)

\_\_\_\_\_  
Date