First Canadian Insurance Corporation

320 SIOUX ROAD
SHERWOOD PARK, ALBERTA
CANADA T8A 3X6
TEL: (780) 467-9575
FAX: (780) 467-4650

CRITICAL ILLNESS CLAIM APPLICATION FORMS

"INSTRUCTIONS"

ALL OF THE FOLLOWING PROPERLY COMPLETED FORMS ARE ESSENTIAL TO THE PROMPT PROCESSING OF YOUR CLAIM:

- INFORMATION RELEASE FORM
- CLAIMANT'S STATEMENT
- ATTENDING PHYSICIAN'S STATEMENT

Please ensure that all the attached forms are fully completed and that all details listed on the forms are provided by you and your doctor. (Incomplete forms will be returned for correction which will delay our claim process and our service to you.)

IN ADDITION, OUR OFFICE WILL REQUIRE THE FOLLOWING INFORMATION (DEPENDING ON YOUR ILLNESS):

Life Threatening Cancer	• The referral letter from your doctor to your cancer centre. • The original biopsy results.
Heart Attack	• The Electrocardiogram (ECG) results. • Confirmation of Elevated Cardiac Enzymes.
Stroke	• A copy of your CT Scan.
Major Organ Transplant	• Your letter of acceptance into a recognized transplant program.
Paralysis	• Nerve conductions studies at time of diagnosis, and 90 days subsequent to this event.

This does not eliminate our potential need to contact your physician directly, however, may help our office expedite your claim. If you are unable to provide this information to us, our office will request this information directly from your doctor.

Before you submit your claim for benefits, please read your Certificate of Insurance carefully, in particular the sections entitled "LIMITATIONS AND EXCLUSIONS" and the Critical Illness portion under DEFINITIONS.

Under conditions of the policy, proof of claim must be submitted to our company on forms supplied by the company within **ninety days** of the event.

We remind you that it remains your responsibility to continue to make your payments to your Lender until your claim is accepted and approved for payment by us. Our terms of payment as an Insurer will differ from the terms of payment required by your Lender, therefore, we recommend that you contact your Lender to ensure that you do not default on your obligation pending claim settlement. **ALL APPROVED BENEFITS ARE FORWARDED DIRECTLY TO YOUR FINANCIAL INSTITUTION.**

PROMPT REPORTING OF YOUR CLAIM IS IMPORTANT.
(Immediately following eligibility)

UPON RECEIPT OF YOUR COMPLETED CLAIM FORMS WE WILL NOTIFY YOU:

- IF WE NEED MORE INFORMATION
- WHEN YOUR CLAIM IS APPROVED AND PAID
- IF YOUR CLAIM CANNOT BE PROCESSED AND THE REASONS WHY

THE INITIAL EXPENSES REQUIRED FOR PROVIDING THE PROOF OF CLAIM INFORMATION ARE THE RESPONSIBILITY OF THE CLAIMANT

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INFORMATION RELEASE FORM

Before First Canadian Insurance Corporation "FCIC" can determine if you are eligible to receive compensation for your illness, it may be necessary that we obtain additional information on your behalf, to assist us in determining eligibility.

This may consist of contacting *physician(s), hospital, or other medical health care professionals*, for personal health information (your medical history) and/or your present treatment, your *provincial health care organization* for an outline of benefits paid, and your *pharmacy*, for a list of your prescribed medications.

In the case of a Motor Vehicle Accident, our office may require details surrounding your accident from the applicable *law enforcement* agency and your *insurance company*.

In all cases, we will need to contact your *financial institution (secured lender)* for loan verification, and updates regarding the status of your account, as all approved benefits are forwarded directly to them to be applied to your loan.

FCIC, in all cases, will advise you when information is requested on your behalf. If you require any clarification regarding the necessity of requesting any information on your behalf, please feel free to contact our Claims Department.

You may withdraw your consent at any time, by advising our office, in writing.

FCIC, under no circumstances (unless required by law) will release the information received as a result of this release to a third party.

I hereby authorize any physician and other medical health care professionals, provincial health care organization, hospital, financial institution (secured lender), law enforcement agency, insurance company, information bureau, or any organization or person with records or knowledge, of the Insured's health, to release the necessary information to First Canadian Insurance Corporation. A facsimile or photocopy of this authorization shall be as valid as the original.

Signature of Claimant

Print Name

Date of Consent

End Date of Consent (if any)

Witness Signature

Witness Print Name

Certificate Number
(See Application for Insurance)

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Signature of Claimant

Print Name

Date of Consent

End Date of Consent (if any)

Witness Signature

Witness Print Name

Certificate Number
(See Application for Insurance)

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CLAIMANT'S STATEMENT

SECTION 1 - INFORMATION ABOUT YOU

FULL NAME ❑ Mr. ❑ Mrs. ❑ Ms.	MAILING ADDRESS	DATE OF BIRTH MONTH DAY YEAR **Please supply a copy of your Driver's License**
TELEPHONE *(PLEASE INCLUDE AREA CODE)* HOME ( ) WORK ( )	CITY / PROVINCE	CERTIFICATE NUMBER
EMAIL: DO YOU CONSENT TO CORRESPONDING VIA EMAIL? ❑ YES ❑ NO	POSTAL CODE	PROVINCIAL HEALTH CARE NUMBER
HAVE YOU RESIDED IN THE SAME PROVINCE DURING THE SIX (6) MONTHS PRIOR TO THE EFFECTIVE DATE OF YOUR POLICY? ❑ YES ❑ NO IF NO, PLEASE PROVIDE YOUR PREVIOUS ADDRESS:		

SECTION 2 - DETAILS OF YOUR FINANCIAL OBLIGATION

DATE VEHICLE PURCHASED MONTH DAY YEAR	NAME OF DEALERSHIP WHERE VEHICLE PURCHASED	
VEHICLE DESCRIPTION *YEAR* *MAKE* *MODEL*		
VEHICLE IDENTIFICATION NUMBER (VIN)		
FINANCIAL INSTITUTION (SECURED LENDER)	FINANCIAL INSTITUTION (SECURED LENDER) ADDRESS	PHONE ( ) FAX ( )
HAS THIS LOAN BEEN RE-WRITTEN OR REVISED? ❑ YES ❑ NO IF SO, PLEASE PROVIDE DETAILS	LOAN NUMBER	MONTHLY PAYMENT
PLEASE PROVIDE A COPY OF THE FINANCE / LEASE CONTRACT. (IF THERE ARE ANY ADDENDUMS AND/OR REVISIONS, PLEASE INCLUDE THIS DOCUMENTATION.)		
DO YOU HAVE MORE THAN ONE ACTIVE LOAN / LEASE INSURED THROUGH FIRST CANADIAN INSURANCE CORPORATION? ❑ YES ❑ NO IF SO, YOU WILL NEED TO SUPPLY ALL INFORMATION IN SECTION 2 FOR YOUR OTHER FINANCIAL OBLIGATION(S)		

SECTION 3 - ABOUT YOUR ILLNESS / INJURY

WHAT IS THE ILLNESS OR INJURY FOR WHICH YOU ARE CLAIMING BENEFITS?		LOCATION OF ACCIDENT ❑ HOME ❑ WORK ❑ ELSEWHERE If elsewhere, please elaborate: _____
WHEN DID THESE SYMPTOMS FIRST APPEAR? MONTH DAY YEAR	WHEN DID YOU FIRST ATTEND YOUR PHYSICIAN FOR THIS CONDITION? MONTH DAY YEAR	WHEN DID YOU FIRST ATTEND YOUR SPECIALIST FOR THIS CONDITION? MONTH DAY YEAR
HAVE YOU EVER HAD THE SAME OR SIMILAR CONDITION BEFORE? YES / NO IF SO, WHEN? MONTH DAY YEAR		NAME OF TREATING PHYSICIAN: _____

Continued on next page

WERE YOU HOSPITALIZED? ❑ YES ❑ NO	IF "YES", NAME OF HOSPITAL ***PLEASE PROVIDE A COPY OF THE EMERGENCY ROOM REPORT AND THE DISCHARGE SUMMARY***	DATES HOSPITALIZED FROM TO
NAME OF DOCTOR TREATING THIS DISABILITY WHEN DID YOU BECOME PART OF THIS DOCTOR'S PRACTICE?	DOCTOR'S ADDRESS CITY PROVINCE POSTAL CODE	DOCTOR'S TELEPHONE PHONE ( ) FAX ( )
NAME OF FAMILY DOCTOR OF INSURED WHEN DID YOU BECOME PART OF THIS DOCTOR'S PRACTICE?	DOCTOR'S ADDRESS CITY PROVINCE POSTAL CODE	DOCTOR'S TELEPHONE PHONE ( ) FAX ( )
NAME OF FAMILY DOCTOR ON EFFECTIVE DATE OF COVERAGE WHEN DID YOU BECOME PART OF PRACTICE?	DOCTOR'S ADDRESS CITY PROVINCE POSTAL CODE	DOCTOR'S TELEPHONE PHONE ( ) FAX ( )
PLEASE LIST THE PHARMACY(IES) WHERE YOU HAVE YOUR MEDICATIONS FILLED 1.	PHONE NUMBER(S)	MEDICATIONS FILLED
2.		
3.		
4.		

PLEASE PROVIDE A LIST OF ALL OTHER INSURANCE COMPANIES FOR WHICH YOU HAVE INSURANCE COVERAGE, INCLUDING ADDRESS, TELEPHONE NUMBER AND CONTACT INFORMATION.

PLEASE PROVIDE OUR OFFICE WITH ANY ADDITIONAL INFORMATION YOU FEEL WILL ASSIST IN THE ADJUDICATION OF YOUR CLAIM.

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature _____ Date _____

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ATTENDING PHYSICIAN'S STATEMENT

(TO BE COMPLETED BY YOUR SPECIALIST)

NOTE TO DOCTOR: THIS STATEMENT WILL BE USED TO DETERMINE YOUR PATIENT'S BENEFITS. CLEAR AND COMPLETE INFORMATION AS TO CAUSE, PROGNOSIS AND TREATMENT WILL SPEED PROCESSING OF THE CLAIM.

NAME OF PATIENT	DATE OF BIRTH MONTH DAY YEAR	CERTIFICATE #

WHAT IS THIS PATIENT'S DISABLING CONDITION (DIAGNOSIS).

PLEASE PROVIDE DATE OF DIAGNOSIS: MONTH DAY YEAR

PLEASE COMPLETE THE APPROPRIATE BOX, SPECIFIC TO YOUR PATIENT'S ILLNESS / INJURY.

LIFE THREATENING CANCER:

PLEASE PROVIDE THE STAGE / GRADE: _____

HEART ATTACK:

WAS THERE NEW ELECTROCARDIOGRAPHIC CHANGES? ❑ YES ❑ NO (PLEASE PROVIDE THESE TEST RESULTS)

WAS THERE AN ELEVATION OF CARDIAC ENZYMES? ❑ YES ❑ NO (PLEASE PROVIDE THESE TEST RESULTS)

STROKE:

WAS THIS A TIA? ❑ YES ❑ NO

HAS THERE BEEN A PERMANENT, MEASURABLE, NEUROLOGICAL DEFICIT, PERSISTING FOR AT LEAST 30 DAYS? ❑ YES ❑ NO

PLEASE EXPLAIN, AND PROVIDE COPIES OF ALL SUPPORTING DOCUMENTATION.

MAJOR ORGAN TRANSPLANT

PLEASE PROVIDE THE CAUSE OF YOUR PATIENT'S FAILED ORGAN:

DOES HIS/HER CONDITION MEDICALLY WARRANT TRANSPLANTATION? ❑ YES ❑ NO

HAS HE/SHE BEEN ACCEPTED INTO A RECOGNIZED TRANSPLANT PROGRAM? ❑ YES ❑ NO (if so, please provide a copy of the acceptance letter). (if not, please explain why)

PARALYSIS:

WHAT MEDICAL CONDITION HAS CAUSED THIS PATIENT'S PARALYSIS?

HAS THIS PATIENT'S PARALYSIS BEEN FOR A CONTINUOUS PERIOD OF 90 DAYS OR MORE? ❑ YES ❑ NO (Please provide these test results)

Continued on next page

PLEASE PROVIDE A BRIEF HISTORY OF CONDITION:

WHAT SYMPTOMS AND/OR RISK FACTORS HAS THIS PATIENT PREVIOUSLY PRESENTED WITH THAT WOULD CONTRIBUTE TO THIS CONDITION? (PLEASE EXPLAIN)

HISTORY OF ILLNESS TO THE BEST OF MY KNOWLEDGE, PATIENT'S SYMPTOMS FIRST APPEARED MONTH DAY YEAR	PATIENT WAS MOST RECENTLY SEEN FOR THIS CONDITION MONTH DAY YEAR
PATIENT WAS FIRST SEEN FOR THIS CONDITION MONTH DAY YEAR	PATIENT HAS BEEN PART OF MY PRACTICE SINCE MONTH DAY YEAR

TO THE BEST OF YOUR KNOWLEDGE, HAS THE PATIENT PREVIOUSLY SUFFERED FROM THE SAME OR SIMILAR CONDITION? ❑ YES ❑ NO

IF YES, PLEASE PROVIDE THE DATES PREVIOUSLY ATTENDED FOR THIS CONDITION.

DID THE PATIENT FULLY RECOVER? ❑ YES ❑ NO IF SO, WHEN?

IS THIS CONDITION DRUG RELATED? ❑ YES ❑ NO IF SO, PLEASE LIST THE DRUG(S), AND HOW THEY RELATE.

IS THIS CONDITION ALCOHOL RELATED? ❑ YES ❑ NO

DESCRIBE FREQUENCY OF ATTENDANCE (EG: WEEKLY, MONTHLY)	LIST ALL DATES ATTENDED FOR THIS CONDITION:
PLEASE PROVIDE THIS PATIENT'S TREATMENT OUTLINE.	IS THE PATIENT FOLLOWING RECOMMENDED TREATMENT? ❑ YES ❑ NO IF NO, PLEASE COMMENT:

WHEN WAS THIS PATIENT REFERRED TO YOU? MONTH DAY YEAR NAME OF REFERRING PHYSICIAN: _____ PLEASE PROVIDE A COPY OF THE REFERRAL LETTER AND ANY SUBSEQUENT CONSULTATION REPORTS. HAVE YOU PREVIOUSLY ATTENDED THIS PATIENT? ❑ YES ❑ NO IF SO, WHEN? MONTH DAY YEAR FOR WHAT CONDITION(S)? _____	PLEASE LIST OTHER ATTENDING HEALTH CARE PROFESSIONALS FOR THIS CONDITION (NAME, ADDRESS AND TELEPHONE) *IF THERE ARE ANY REPORTS AVAILABLE FROM THESE SOURCES, PLEASE INCLUDE IN YOUR RESPONSE.*

ADDITIONAL INFORMATION: PLEASE PROVIDE ANY ADDITIONAL INFORMATION OR COMMENTS THAT MAY BE HELPFUL IN ASSESSING YOUR PATIENT'S CLAIM.

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNED AT: CITY PROVINCE	DATE: MONTH DAY YEAR
SIGNATURE OF SPECIALIST	PRINTED NAME AND ADDRESS OF SPECIALIST

ANY CHARGES FOR THE COMPLETION OF THIS FORM OR THE PROVISION OF RELATED DOCUMENTS ARE THE RESPONSIBILITY OF THE CLAIMANT