First Canadian Insurance Corporation

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

DISABILITY CLAIM APPLICATION FORMS

For

Standard / Partial Payment and Dismemberment Plans

"INSTRUCTIONS"

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

- INFORMATION RELEASE FORM
- CLAIMANT'S STATEMENT
- EMPLOYER'S STATEMENT
- INITIAL DISABILITY INSURANCE MEDICAL STATEMENT

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

NOTE: You must also provide the following documents:

- ❑ A copy of your finance contract (For lender/loan verification)
- ❑ A copy of your driver's license (For confirmation/verification of age)
- ❑ A copy of your motor vehicle accident (MVA) report and damage repair estimate (for disabilities arising from an MVA)
- ❑ A copy of your acceptance/denial letter from your provincial workers compensation board (if your injury/illness is work related)
- ❑ A copy of your Record of Employment from your previous occupation (if your current employer differs from your employer on the Effective Date of Insurance)

Before you submit your claim for benefits, please read your Certificate of Insurance carefully; in particular the section entitled "LIMITATIONS AND EXCLUSIONS".

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 giving rise to the claim, and you must be totally disabled for longer than the waiting period specified on your Certificate of Insurance to claim benefits. If approved, Disability Benefits will be calculated from no earlier than 90 days prior to the date that proof of claim was received. In no event will a proof of claim be considered valid when submitted more than one year after the event giving rise to the claim.

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 LENDER.

PROMPT REPORTING OF YOUR CLAIM IS IMPORTANT.
(Immediately following an eligible disability)

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 disability, 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. We may also, from time to time, contact your *physicians,* or *other medical health care professionals* for updates regarding your condition.

Also, we may be required to contact your present and/or previous employer to clarify your employment status at the time this policy was purchased, details surrounding your job function(s), and verification of a return to work date.

In the case of a Motor Vehicle Accident (or acute injury, if applicable), 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 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, Lender, employer, law enforcement agency, insurance company, information bureau, or any organization or person with records or knowledge, of the Insured's health and employment, to release the necessary information to First Canadian Insurance Corporation. I authorize the Lender to release a copy of my Finance Contract, Statement of Account as well as loan verification and updates as required. A facsimile or photocopy of this authorization shall be as valid as the original.

_____
Signature of Claimant

_____
Print Name

_____
Date

This Consent is Valid for:
- ❑ The Term of the Policy
- ❑ This Claim only
- ❑ Other _____

_____
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	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

LOAN DATE MONTH DAY YEAR	AGENT/AGENCY	
LENDER	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 CONTRACT. (IF THERE ARE ANY ADDENDUMS AND/OR REVISIONS, PLEASE INCLUDE THIS DOCUMENTATION.)		
DO YOU HAVE MORE THAN ONE ACTIVE LOAN 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 DISABILITY

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	HAVE YOU HAD THE SAME OR SIMILAR CONDITION BEFORE? IF SO, WHEN? MONTH DAY YEAR NAME OF TREATING PHYSICIAN: _____
IF YOUR CONDITION IS THE RESULT OF AN INJURY, PLEASE DESCRIBE HOW THE INJURY OCCURRED.		
PLEASE OUTLINE YOUR SYMPTOMS, AND HOW THEY PREVENT YOU FROM RETURNING TO WORK.		

Continued on next page

IS YOUR CLAIM WORK RELATED? ❑ YES ❑ NO IF YES, PLEASE PROVIDE YOUR WCB CLAIM # _____ NAME AND PHONE NUMBER OF ADJUSTER: _____ **PLEASE ALSO SUPPLY A COPY OF YOUR WCB ACCEPTANCE / DENIAL LETTER.**	IF YOUR CLAIM IS WORK RELATED BUT WCB HAS NOT ACCEPTED YOUR CLAIM (OR YOU HAVE NOT SUBMITTED A CLAIM) PLEASE PROVIDE DETAILS REGARDING THIS.
IS YOUR CLAIM THE RESULT OF A MOTOR VEHICLE ACCIDENT? ❑ YES ❑ NO **ENCLOSE A COPY OF THE MOTOR VEHICLE ACCIDENT REPORT AND A COPY OF THE DAMAGE REPAIR ESTIMATE (or PROOF OF LOSS STATEMENT)**	AUTO INSURER NAME: _____ INSURER'S CLAIM NO: _____ ADJUSTER'S NAME: _____ ADJUSTER'S PHONE NUMBER: ( ) _____

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 ( )
DETAILS OF TREATMENT FROM ANY OTHER FACILITY (ie. Physiotherapy/Chiropractic) WHEN DID YOU BECOME A PART OF THIS PRACTICE?	FACILITY'S ADDRESS CITY PROVINCE POSTAL CODE	FACILITY'S TELEPHONE PHONE ( ) FAX ( )
NAME OF FAMILY DOCTOR OF INSURED WHEN DID YOU BECOME A PART OF THIS 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 A PART OF THIS 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.		
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

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

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT ALL PHONE CONVERSATIONS WITH FCIC REPRESENTATIVES ARE RECORDED FOR QUALITY ASSURANCE, TRAINING PURPOSES, AND DISPUTE RESOLUTION.

_____ Signature

_____ Date

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EMPLOYER'S STATEMENT

(TO BE COMPLETED BY YOUR PRESENT EMPLOYER)

IF SELF-EMPLOYED ALSO COMPLETE PAGE 4a

EMPLOYEE NAME (CLAIMANT)	EMPLOYEE ID NUMBER

NAME OF EMPLOYER (COMPANY NAME)	EMPLOYER ADDRESS	EMPLOYER TELEPHONE
	CITY PROVINCE POSTAL CODE	PHONE ( ) FAX ( )
DATE EMPLOYEE STARTED EMPLOYMENT WITH YOUR COMPANY MONTH DAY YEAR	EMPLOYMENT TYPE ❑ FULL TIME ❑ PART TIME ❑ CASUAL ❑ SEASONAL ❑ APPRENTICE	LAST DATE EMPLOYEE WORKED MONTH DAY YEAR

IF PART TIME OR CASUAL, PLEASE DESCRIBE SCHEDULE AND AVERAGE NUMBER OF HOURS WORKED PER WEEK.	
IF SEASONAL, HOW MANY YEARS HAS THE EMPLOYEE WORKED FOR THIS COMPANY?	IF SEASONAL, PLEASE PROVIDE THE YEARLY WORK SCHEDULE

WHAT IS THIS EMPLOYEE'S OCCUPATION?	PLEASE DESCRIBE THE MAIN DUTIES OF THIS OCCUPATION
DOES YOUR EMPLOYMENT OFFER LIGHT/MODIFIED DUTIES TO EMPLOYEES? ❑ YES ❑ NO	IF SO, PLEASE BRIEFLY OUTLINE:
HAS THIS EMPLOYEE PERFORMED OTHER OCCUPATIONS FOR YOUR COMPANY? ❑ YES ❑ NO	IF SO, PLEASE LIST JOBS PERFORMED, AND THE MAIN DUTIES OF THESE JOBS.

WAS THIS A WORK RELATED INJURY? ❑ YES ❑ NO	IS THERE A WCB CLAIM? ❑ YES ❑ NO PROVIDE CLAIM NUMBER: _____	HAS EMPLOYEE HAD PRIOR TIME OFF FOR THE SAME OR SIMILAR CONDITION? ❑ YES ❑ NO IF SO, WHEN? _____	WAS THE LAST DAY WORKED DUE TO: ❑ TERMINATION ❑ LAYOFF ❑ STRIKE ❑ DISABILITY ❑ QUIT ❑ LOCK-OUT ❑ OTHER, PLEASE SPECIFY: _____

HAS THE EMPLOYEE WORKED ANY DAYS SINCE THE DATE OF THE DISABILITY? ❑ YES ❑ NO	IF YES, PLEASE SPECIFY DATES:	**EMPLOYEES ANTICIPATED DATE OF RETURN TO WORK** LIGHT DUTIES MONTH DAY YEAR NORMAL DUTIES MONTH DAY YEAR

PLEASE PROVIDE THE NAME AND PHONE NUMBER OF YOUR EMPLOYEE GROUP MEDICAL PLAN, INCLUDING ANY I.D. NUMBERS RELATING TO THIS EMPLOYEE:

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

EMPLOYER REPRESENTATIVE SIGNATURE

PRINTED NAME IN FULL

TITLE

DATE

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

Continued on next page

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EMPLOYMENT INFORMATION AT THE TIME OF POLICY PURCHASE
(complete only if different from present employer)

Please provide a copy of your Record of Employment that was issued by your Previous Employer

NAME OF PREVIOUS EMPLOYER	EMPLOYER ADDRESS	PHONE ( ) FAX ( )
DATE YOU STARTED WITH THIS COMPANY	LAST DATE YOU WORKED MONTH DAY YEAR	
❑ FULL TIME ❑ APPRENTICE ❑ PART TIME ❑ CASUAL ❑ SEASONAL ❑ UNEMPLOYED	OCCUPATION AND DESCRIPTION	

COMPLETE IF YOU ARE SELF-EMPLOYED

PLEASE PROVIDE:

❑ PHOTOCOPY OF YOUR BUSINESS LICENSE

❑ PHOTOCOPY OF YOUR BUSINESS NOTICE OF ASSESSMENT FROM REVENUE CANADA FOR THE FOLLOWING PERIODS:

- THE YEAR YOU PURCHASED YOUR POLICY
- THE MOST RECENT YEAR PRIOR TO YOUR DISABILITY

❑ PLEASE ALSO PROVIDE THE STATEMENT OF BUSINESS OR PROFESSIONAL ACTIVITIES (T2125), OR, IF YOUR BUSINESS REQUIRES AN ALTERNATE STATEMENT (IE. STATEMENT OF FARMING ACTIVITIES (T2042) FOR BOTH RELEVANT PERIODS ABOVE.

ONCE THESE DOCUMENTS HAVE BEEN REVIEWED, WE WILL ADVISE YOU IF FURTHER INFORMATION IS REQUIRED. THIS MAY INCLUDE A REQUEST FOR THE FOLLOWING:

❑ PHOTOCOPIES OF BUSINESS INVOICES FOR THE PERIOD ONE MONTH PRIOR TO THE PURCHASE AND ONE MONTH PRIOR TO THE ONSET OF YOUR DISABILITY.

❑ PHOTOCOPIES OF BUSINESS BANK STATEMENTS FOR THE PERIOD ONE MONTH PRIOR TO THE PURCHASE AND ONE MONTH PRIOR TO THE ONSET OF YOUR DISABILITY.

YOUR CLAIMS EXAMINER CAN DISCUSS THE SPECIFICS OF WHAT IS REQUIRED TO SUPPORT YOUR EMPLOYMENT ELIGIBILITY ONCE YOUR CLAIM FORMS ARE RECEIVED.

NAME OF COMPANY: _____ LEGAL ENTITY NAME: _____ (FOR NUMBERED COMPANIES)

DATE YOUR BUSINESS STARTED: _____ NUMBER OF EMPLOYEES: _____ PERCENTAGE OF OWNERSHIP: _____

PLEASE PROVIDE THE DATE LAST WORKED DUE TO YOUR DISABILITY: _____

ARE YOU CURRENTLY PERFORMING ANY DUTIES OF YOUR OCCUPATION? ❑ YES ❑ NO

IF SO, PLEASE LIST THESE DUTIES AND HOW THEY DIFFER FROM YOUR NORMAL DUTIES:

TYPE OF EMPLOYMENT: ❑ FULL TIME ❑ PART TIME ❑ SEASONAL

IF SEASONAL, PLEASE LIST USUAL MONTHS OF EMPLOYMENT: _____

CLHIA ACCAP

First Canadian Insurance Corporation

The patient is responsible for any fees related to the completion of this form.

Initial Disability Insurance Medical Statement

Section 1 — Patient Information and Consent
TO BE COMPLETED BY THE PATIENT

Patient Name (Last, First, Middle Initial)	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)

Address (Street, City, Province, Postal Code)

Employer's Name (if applicable)	Contract or Policy #	Certificate # (if applicable)	Date of Birth (dd/mm/yyyy)

Date Last Worked
(dd/mm/yyyy) _____

Date Returned to Work or Expected Return to Work Date
(dd/mm/yyyy) _____

Please list your present medications:

	Name of Medication	Dosage (mg)	How Often?
1.			
2.			
3.			
4.			
5.			

Please provide your:

Height: _____

Weight: _____

Dominant Hand:

Left ☐ Right ☐

I hereby authorize the release of medical and health information in my file to First Canadian Insurance Corporation and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan/insurance policy. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim cannot be assessed. I understand that I am responsible for any fees related to the completion of this form. **Medical and health information excludes genetic test results.**

_____ _____

Patient Signature — Date of Consent (dd/mm/yyyy)

Section 2 — Medical Statement
TO BE COMPLETED BY THE DOCTOR (or applicable medical provider)

I am the: Family Physician ☐ Consulting Specialist ☐ Other ☐ (please specify) _____

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Diagnosis

Primary: _____

_____

Secondary and/or Complications: _____

_____

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): Vaginal ☐ C-Section ☐

Is this condition due to:

Occupational Illness Yes ☐ No ☐

Occupational Injury Yes ☐ No ☐

Motor vehicle accident Yes ☐ No ☐

Other accident Yes ☐ No ☐

If yes, date of event: (dd/mm/yyyy) _____

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____

Date of first visit to you pertaining to this condition: (dd/mm/yyyy) _____

First date of work absence due to condition: (dd/mm/yyyy) _____

Treatment

e.g. Special Programs, Therapies, Medications: (if not noted by patient in **Section 1)**

_____

_____

_____

_____

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐ (describe) _____

Date of last visit: (dd/mm/yyyy) _____

Date of next visit: (dd/mm/yyyy)

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐ Unknown ☐

If yes, date: (dd/mm/yyyy) _____ Treatment Provider: _____

Is the patient following the recommended treatment program? Yes ☐ No ☐

Please elaborate: _____

Response to Treatment

Please describe the response to treatment to date: Complete ☐ Partial ☐ None ☐ Too soon to tell ☐

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain: _____

_____

_____

Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐ Is future hospitalization planned? Yes ☐ No ☐

Did/will the patient have day surgery? Yes ☐ No ☐

Please provide the following information or attach a copy of the admission, discharge, and/or operative report(s):

	Date of admittance (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Institution Name
1.			
2.			
3.			

If surgery was/will be performed, please provide date(s) and description of surgery(s):

	Date (dd/mm/yyyy)	Description
1.		
2.		

- **If your patient has returned to work, or if the duration of their disability will be less than 4 weeks, please stop here and sign the end of the form.**
- **For disabilities expected to be greater than 4 weeks, please complete all pages.**

Investigations

Please attach copies of all relevant:

- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed) - do not provide genetic test results**
- **consultation reports**
- **clinical notes**

Are tests/investigations pending? Yes ☐ No ☐

	Date (dd/mm/yyyy)	Description
1.		
2.		

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes ☐ No ☐

	Name of Specialist	Specialty	Date (dd/mm/yyyy)
1.			
2.			

Clinical Findings and Observations

Please describe the patient's symptoms including history, severity and frequency:

How have the patient's symptoms evolved to date? Improved ☐ No Change ☐ Retrogressed ☐

Restrictions and Limitations

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations: _____

Has any license held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐

If yes, as of when? (dd/mm/yyyy) _____ Type of license: _____

Is the patient capable of managing their own affairs? Yes ☐ No ☐

Are there other contributing factors that you are aware of that may impact the patient's expected recovery period and return-to-work goals?

Yes ☐ No ☐

Workplace Issues ☐ Social/Family Issues ☐ Financial/Legal Issues ☐ Personality issues ☐ Addiction ☐ Other ☐

Please elaborate: _____

Prognosis

Please provide the patient's prognosis for improvement and/or recovery:

Return-to-Work

What return-to-work goals have been discussed with the patient? Please elaborate:

Notice to Physician/Medical Provider:

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Name of Attending Physician/Medical Provider (please print)	Specialty and license/registration number	Date Signed (dd/mm/yyyy)

Address (Street, City, Province, Postal Code)	Telephone # (+ area code) Fax # (+ area code) Email address

Signature