BMO Bank of Montreal

Mortgage Critical Illness Insurance Claim Creditor Insurance – Policy no. 57904

Sun Life Financial

BMO Bank of Montreal Representative:

First name	Last name
Signature X	
Telephone number – –	Fax number – –
Date (dd-mm-yyyy) – –	

Branch Domicile Stamp

What information is required for a Critical Illness claim?

Checklist:

☐ a completed Bank Statement
☐ a completed and signed Claimant Statement
☐ a completed and signed Attending Physician's Statement*
☐ a copy of the Mortgage Insurance Application(s) pertaining to this claim

* You must complete the Patient Authorization on the Attending Physician's Statement. Ask your doctor to complete the Attending Physician's Statement with as many details as possible. The statement should be immediately given to you to submit with your claim.

Sun Life Assurance Company of Canada can only process your claim when we have received all of the above documents fully completed. To prevent delays, please be sure the forms are completed in full and provide as much information as possible to help with the adjudication of your claim.

Please return your completed claim package in a sealed envelope except for the Bank's Statement to your Branch. The Bank will submit your claim forms to Sun Life on your behalf.

Important Notes

- Proof of claim must be submitted within 180 days of the date of diagnosis.
- Any costs for information to substantiate your claim is your responsibility.
- The Physician's Statement must be completed by a qualified medical practitioner practising in Canada or the United States of America.
- Please retain a photocopy of your claim forms for your records.
- Sun Life Assurance Company of Canada will inform you if your claim is subject to further investigations.
- Until Sun Life Assurance Company of Canada advises you in writing of the decision, it is your responsibility to continue paying your mortgage payments in full.
- For questions about your claim, you may call Sun Life Assurance Company of Canada at 1-877-271-8713.

BMO Bank of Montreal

Mortgage Critical Illness Insurance Claim Creditor Insurance – Policy no. 57904

Sun Life Financial

Bank's Statement

Instructions

- Sections 1, 2, 3 and 4 to be completed by the Bank of Montreal Branch
- Attach a copy of the Mortgage Insurance Application(s) pertaining to this claim
- Give the entire claim package to the customer to complete
- Advise the customer to return the claim package in a sealed envelope (except for the Banks's Statement) to the Branch
- Send the completed claim package in a sealed envelope along with the Bank's Statement to the Mortgage Service Centre (MSC) for completion of Section 5 and 6

1 Insured's information

First name	Last name	☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr.	Language ☐ English ☐ French
Date of birth (dd-mm-yyyy)	Date of diagnosis (dd-mm-yyyy)	Telephone number	
Address (street number and name)		Apartment or suite	
City	Province	Postal code	

2 Mortgage information

Mortgage number	Effective date of insurance (dd-mm-yyyy)
Is this mortgage ☐ New ☐ Refinanced – If refinanced, was it previously insured? ☐ Yes ☐ No ☐ Pre-approved mortgage – If *yes*, what is the closing date (dd-mm-yyyy)	
Authorized amount $	Current premium payments at date of Critical Illness Disability $ ☐ Monthly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly Life $ ☐ Monthly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly Critical Illness $ ☐ Monthly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly Job loss $ ☐ Monthly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly
Current balance $	Percent of balance covered ☐ 50 % ☐ 100% ☐ Other
	Coverage status ☐ Active ☐ Ineligible ☐ Approved ☐ Waived ☐ Pending

3 Insured co-borrower

Last name	First name	Last name	First name
1		5	
2		6	
3		7	
4		8	

4 Lender information

First name	Last name	
Telephone number	Transit number	Current date (dd-mm-yyyy)

I am an authorized representative of the Bank of Montreal and I hereby certify that the above information is true and correct.

Signature of lender X	Title

5 Mortgage information – to be completed by the Bank of Montreal Mortgage Service Centre

Calculation of Amount Owing on (date of diagnosis) $ (if Mortgage was partially advanced at the date of diagnosis insert amount of approved Mortgage)	
Principal outstanding	$
Unpaid Interest	$
Principal and unpaid interest owing	$
Amount of debit of tax account	$
Accrued debit interest on tax account	$
Amount owing as of date of diagnosis	$
Bonus payable	$
Discharge fee	$
Total amount owing as at date of diagnosis	$
Total per diem on outstanding amount advanced before date of diagnosis	$

6 Bank of Montreal Mortgage Service Centre Representative

I am an authorized representative of the Bank of Montreal Mortgage Service Centre and I hereby certify that the above information is true and correct.

Dated at (dd-mm-yyyy)	Authorized signer	Title	
Address (street number and name)			Telephone number
City	Province		Postal code

BMO Bank of Montreal

Mortgage Critical Illness Insurance Claim
Claimant's Statement — Creditor Insurance – Policy no. 57904

Sun Life Financial

Proof of claim must be submitted within 180 days of the date of diagnosis.

Instructions

- The "Claimant's Statement" must be fully completed, making sure all questions are answered.
- Please be sure to indicate your mortgage number below.
- Please be sure to sign and date the Claimant Authorization.
- Print clearly in block letters.
- Please return your completed claim package in a sealed envelope except for the Bank's Statement to your Branch.

1 Claimant information

First name			Last name	
Address (street number and name)				
City			Province	Postal code
Date of birth (dd-mm-yyyy)	☐ Male ☐ Female	Language ☐ English ☐ French	Telephone number	☐ Bus. ☐ Res.
Mortgage number				

2 Claim details

Please describe the nature and extent of your critical illness.			
When was your condition diagnosed or surgery performed? (dd-mm-yyyy)		When did symptoms first commence? (dd-mm-yyyy)	
Please describe the symptoms.			
When did you first consult a medical practitioner in connection with your illness? (dd-mm-yyyy)			
Physician's first name		Last name	
Physician's address (street number and name)			Apartment or suite
City	Province	Postal code	Telephone number
Have you undergone any tests or investigations related to the diagnosis? ☐ Yes ☐ No If *yes*, please provide details and dates.			

2 Claim details (continued)

Have you previously suffered from, or received treatment for, a similar or related condition? ☐ Yes ☐ No If yes, please provide details and dates.

3 Medical consultations

Please provide the name and address of your personal physician.

First name	Last name	Specialty
Address (street number and name)		Apartment or suite
City	Province	Postal code

How long has this physician been involved in your care?

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

First name	Last name	Specialty
Address (street number and name)		Apartment or suite
City	Province	Postal code / Date seen (dd-mm-yyyy)

First name	Last name	Specialty
Address (street number and name)		Apartment or suite
City	Province	Postal code / Date seen (dd-mm-yyyy)

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

Name of hospital	City or town
Date of admission (dd-mm-yyyy)	Date of discharge (dd-mm-yyyy)

Please indicate the names and addresses of any other physicians who have treated you in the last 3 years.

First name	Last name	Specialty
Address (street number and name)		Apartment or suite
City / Province / Postal code / Telephone number		Fax

3 Medical consultations (continued)

First name	Last name	Specialty

Address (street number and name)	Apartment or suite

City	Province	Postal code	Telephone number	Fax
			– –	– –

What type(s) of treatment have you received, or are currently receiving, in connection with your condition? (e.g., medications, therapy, etc.).

Type of treatment	
Institution/Prescribing physician	**Date (dd-mm-yyyy)**
	– –

Type of treatment	
Institution/Prescribing physician	**Date (dd-mm-yyyy)**
	– –

4 General

Have any of your immediate family (mother, father, brother, sisters) had cancer, tumor, heart disease, diabetes, kidney disease prior to age 60? ☐ Yes ☐ No If *yes*, please indicate:

Relationship	Nature of illness	Age at which illness was first diagnosed

Relationship	Nature of illness	Age at which illness was first diagnosed

Relationship	Nature of illness	Age at which illness was first diagnosed

Are you insured for Individual Critical Illness benefits with Sun Life or with another company? ☐ Yes ☐ No If *yes*, please indicate:

Name of insurer	Policy number
Amount of benefit insured	**Has a claim been submitted?**
$	☐ Yes ☐ No

Are you currently receiving or have you applied for short or long term disability benefits with Sun Life? ☐ Yes ☐ No If *yes*, please indicate:

Policy number	Certificate number
Case manager's first name	**Case manager's last name**

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	When did you quit? (dd-mm-yyyy)
			– –

Please provide any other information that would be helpful in the assessment of your claim.

5 Claimant authorization

I certify that the statements in this form are true and complete. I understand that Sun Life Assurance Company of Canada may investigate this claim. I authorized Sun Life Assurance Company of Canada, its agents and service providers (i) to collect, use, and disclose information about me (excluding health information) with the Bank of Montreal for the purpose of administering my claim and (ii) to collect, use and disclose information about me (including health information) needed for underwriting, administration and adjudicating claims under this Group Policy with any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. A photocopy of this authorization is as valid as the original and shall continue to have effect throughout the administration of the plan.

Signature of claimant	Date (dd-mm-yyyy)
X	– –

6 Respecting your privacy

We are responsible for all personal information in our possession, including information transferred to a third-party service provider or agent, so that we can provide you with a product or service. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. All such persons, whether or not they are located in Canada, are required to protect the confidentiality of your personal information in a manner that is consistent with our privacy policy and practices.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by email to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

BMO Bank of Montreal

Mortgage Critical Illness Insurance Claim Creditor Insurance – Policy no. 57904

Sun Life Financial

Attending Physician's Statement – Cancer Statement

1 Patient information (This part of the form should be completed before the physician completes part 3)

IMPORTANT: Please note that you are responsible for the cost of completing this form

Patient's first name	Last name	Date of birth (dd-mm-yyyy)
		– –
Address (street number and name)		Apartment or suite
City	Province	Postal code
Telephone number		
– –		

2 Patient's authorization and signature

I authorize my doctor to collect, use and disclose information with Sun Life Assurance Company of Canada, its agents, service providers and reinsurers for the purposes of underwriting, administration and adjudicating my claim under this insurance plan. I agree that a photocopy or electronic version of this authorization is as valid as the original and shall continue to have effect throughout the duration of my claim.

Patient's signature	Date (dd-mm-yyyy)
X	– –

3 Physician information

Your patient would appreciate completion of this form as soon as possible otherwise there maybe delays in processing this claim.

When did your patient first have symptoms? (dd-mm-yyyy)	
– –	
What were the symptoms?	
When did your patient first consult you for this condition? (dd-mm-yyyy)	How long has this person been your patient?
– –	
Please provide the date this cancer was diagnosed. (dd-mm-yyyy)	
– –	
When was the patient advised of the diagnosis? (dd-mm-yyyy)	Advised by whom?
– –	
Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this cancer.	

Please provide a copy of the pathology report giving the following details:

- **Type of Tumour**
- **Site of Tumour**
- **Histology and Staging**

3 Physician information (continued)

Has your patient previously suffered from cancer or any predisposing disorders? If so, please provide dates and details.		
Has your patient ever been tested for the Human Immunodeficiency Virus? ☐ Yes ☐ No	Date (dd-mm-yyyy)	Result
Is there a family history of cancer? ☐ Yes ☐ No	Please provide details.	
Please provide details of any other significant family history.		
Please provide details of your patient's tobacco use, including amount per day and date last used.		
Please provide any other information that would be helpful in the assessment of your patient's claim.		

Please provide copies of all test results, pathology reports, surgical reports and consultation reports with respect to this condition.

4 Physician's authorization and signature

I certify that the information in this form is true and correct.

Physician's first name (please print)	Last name		Degree
Address (street number and name)			Apartment or suite
City	Province	Postal code	Telephone number
Physician's signature X			Date (dd-mm-yyyy)