Business Loan Insurance Plan
Critical Illness Claim - Policy 57903

RBC use only
E-FORM 300240 (08/2015)

Before submitting a critical illness claim:

- Complete and sign the Claimant's Statement for your critical illness.
- Please select the Attending Physician Statement according to your illness you are claiming benefits for.
- Sign and complete the Patient Authorization on the Attending Physician's Statement.
- The doctor must complete the Attending Physician's Statement with as many details as possible.
- The complete critical illness claim package consists of 2 parts
  - a completed and signed Claimant Statement.
  - a completed and signed Attending Physician's Statement according to the illness you are claiming benefits for.

Sun Life Assurance Company of Canada can only process your claim when we have received the Claimant and Physician Statement 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 the claim.

- As our consulting physicians do not examine you, we depend on the quality of the medical information given by your doctor to assess your claim.

To ensure your claim is processed promptly:

- Submit your claim to: Insurance Service Centre
  P.O. Box 53, Postal Station A
  Mississauga, Ontario
  L5A 2Y9
  Transit: 04523
- Please read and follow these instructions carefully.

Until your claim is approved:

- Sun Life Assurance Company of Canada will inform you if further information is required in order to assess your claim.
- Until Sun Life Assurance Company of Canada advises you in writing of the decision, it is your responsibility to continue paying your loan payments in full.
- For questions about your claim, you may call the Insurance Service Centre at 1-800-769-2523.

Important notes:

- Proof of claim must be submitted within 180 days of the date of diagnosis or surgery.
- You are responsible for the costs, if any, of obtaining information to substantiate your claim.
- The Attending Physician's Statement must be completed by a licensed Physician or Specialist.
- Please retain a photocopy of your claim forms for your records.

Sun Life Assurance Company of Canada is a member of the Sun Life Financial group of companies

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Claimant's Statement

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

- The "Claimant’s Statement" must be fully completed, making sure all sections are answered.
- Please be sure to sign and date the Claimant Authorization.
- Print clearly in block letters.

1 Claimant information

First name				Last name		
Address (street number and name)						
City				Province		Postal code
Date of birth (dd-mm-yyyy) 22-06-2015	☐ Male ☐ Female	Language ☐ English ☐ French		Telephone number		☐ Bus. ☐ Res.
Claimant’s SRF number	Business name			Business SRF number		Business loan number

2 Claim details

Please describe the nature 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 physician 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.			

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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 physicians 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 number

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 biological family members (parents, brothers, sisters) had heart disease, kidney disease, stroke, diabetes, cancer, familial colon polyposis or any hereditary disease, the onset of which was prior to age 65? ☐ 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 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

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 authorize Sun Life Assurance Company of Canada, its agents and service providers (i) to collect, use, and disclose information about me (excluding health information) with RBC 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 claim.

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

6 Keeping your information confidential

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.

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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)
		22-06-2015
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 this authorization is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the claim. 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 Medical information

Your patient would appreciate completion of this form as soon as possible otherwise there may be 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

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3 Medical information (continued)

Has your patient previously suffered from cancer or any predisposing disorders? If so, please provide dates and details.	
Is there a family history of cancer? ☐ Yes ☐ No	Please provide details.
Please provide details of any other significant family history.	
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	Fax number	
Physician's signature X		Date (dd-mm-yyyy)

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Attending Physician's Statement - Heart Attack 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) 22-06-2015
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 this authorization is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the claim. 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 **X**	**Date (dd-mm-yyyy)**

3 Medical information

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

When did your patient first consult you for this condition (dd-mm-yyyy)	How long has this person been your patient?
Was a diagnosis of heart attack made? ☐ Yes ☐ No	When was the diagnosis made? (dd-mm-yyyy)

By whom was the diagnosis made?

Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this heart attack.

Please provide description and date of onset of chest pain pertaining to the insured's heart attack.

Please provide ECG changes in detail at time of event.*

Please provide cardiac enzyme levels and/or troponin including CK - MB fraction and percentage of total CK at time of diagnosis pertaining to the insured's heart attack.

What other investigations have been performed? Please provide dates and details, or reports.

***Provide copies of tracings pertaining to the insured's heart attack, if available.**

3 Medical information (continued)

When did your patient first suffer symptoms or episodes of cardiovascular disease? (dd-mm-yyyy)
Please provide details and dates.
Please describe (including dates) any predisposing conditions or risk factors that your patient has had for cardiovascular disease.
Is there a family history of cardiovascular disease or cerebrovascular disease? ☐ Yes ☐ No Please provide details.
Please provide any other information that would be helpful in the assessment of your patient's claim.

Please provide copies of test results and consultation reports with repect to this condition, including a copy of the following:

A) The ECG's that document this heart attack

B) The cardiac enzyme level reports, including CK-MB BANS, Troponin I or Troponin T documenting this heart attack

C) All ECG test results, cardiac enzyme test and consultation and discharge notes

D) Reports of any other cardiac investigation performed such as coronary angiography, echocardiography, etc.

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	Fax number	
Physician's signature X		Date (dd-mm-yyyy)

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Attending Physician's Statement - Stroke 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)
			22-06-2015
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 this authorization is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the claim. 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 Medical information

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

When did your patient first consult you for this condition? (dd-mm-yyyy)	How long has the insured been your patient?
Was a diagnosis of stroke made? ☐ Yes ☐ No	When did the stroke occur? (dd-mm-yyyy)
Please describe the cause of the stroke.	
Please describe the measurable residual neurological deficits.	
How long have the neurological deficits persisted?	By whom was the diagnosis made?
When was the patient advised of the diagnosis? (dd-mm-yyyy)	Advised by whom?

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3 Medical information (continued)

Please give the names and addresses of other physicians consulted or hospitals attended by your patient for this stroke.	
What other investigations have been performed? Please provide dates and details, or reports.	
When did your patient first suffer symptoms or episodes of cerebrovascular disease? (dd-mm-yyyy)	What were they?
Please describe (including dates) any predisposing disorders or risk factors that your patient had for cerebrovascular disease.	
Is there a family history of cardiovascular disease or cerebrovascular disease? ☐ Yes ☐ No	Please provide details.
Please provide any other information that would be helpful in the assessment of your patient's claim.	

Please provide copies of test results and consultation reports including a copy of the CT scan or MRI if available.

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	Fax number	
Physician's signature X		Date (dd-mm-yyyy)