Canadian Premier
LIFE INSURANCE COMPANY

Injury and Sickness / Critical Illness Claims Package

IMPORTANT!

We are pleased to provide you with this claims package. There are some important points we would like to bring to your attention, to ensure that your claim is processed as fast as possible:

1. **Please ensure that every field is fully completed by yourself, your Physician and your employer.**
2. **Please ensure that you enter your email address in "Section 1: Claimants Section". We email most claim communication, and want to be sure that you are always up to date with the status of your claim.**
3. **On the last page of this claims package is the 'What Happens Now' section. Please read this section so you know exactly what to expect with the claim, and specifically the last section that requires your signature acknowledging you must return this claims package within five business days.**

Before sending in the claims package please ensure that you thoroughly go over the 'Claims Checklist' on page 2 of this claims package to ensure you have everything complete and supporting documents attached. While emailing is preferred, you can submit your completed claims package using any of the four methods below:

1. **Email:** claims@premiumservicesgroup.ca
2. **Claims Fax:** 1.888.341.4888
3. **Mail:** Premium Services Group
   300- 495 Richmond St.,
   London ON N6A 5A9
4. **Upload by Lender:** If you choose, you may request that the Lender upload the claims documents directly to Premium Services Group on your behalf by completing the Consent Form below.

CONSENT FORM

To: _____ [Name of lender] (**the** "Lender")

I hereby confirm that I have requested that the Lender scan and submit certain claims and other related forms (the "Forms**") to Premium Services Group Inc. ("**PSG**") on my behalf. I consent to the collection, use and disclosure of my personal information contained in the Forms by the Lender for the purpose of uploading and transmitting such Forms to PSG, provided that the Lender shall either return to me or securely destroy the Forms following such transmission and shall not retain any personal information contained in the Forms.**

Dated _____
Month / Day / Year

_____
Claimant Signature

_____
Claimant Name (please print)

Cash Money Cheque Cashing Inc. is not the insurer and plays no part in determining coverage or in claims adjudication or disposition.

Canadian Premier
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Injury and Sickness / Critical Illness
Claim Forms

Administration Office	
Premium Services Group 300- 495 Richmond St., London ON N6A 5A9	Claims Info: **1-866-766-4566 ext. 4056** Claims Fax: **1-888-341-4888** Claims Email: **claims@premiumservicesgroup.ca**

Claim Information

Date: _____ (dd/mm/yy) No. of Pages:_____ (incl. cover)

Claimant's Name: _____

Phone: _____ ext._____ E-mail: _____

Claim Checklist

Please note that ALL claims info must be received in order to process claim

(Please check boxes when completed)

Claim Forms completed in full? ***(including Doctor's/Employer's section completed)***	
Copy of line of credit documents outstanding on date of disability?	
Additional Information? *(please note)*	

IMPORTANT

1. the administration office must be notified within **30 days** of your date of injury, sickness or critical illness

2. the completed claim form (*see checklist below*) must be submitted to the administration office within **90 days** of the date of your injury, sickness or critical illness

Submitted By:	Please Note
Customer	• Please ensure ALL documents are faxed/emailed to the contact info above • Please watch for email confirmation from PSG that file was received (If you are sending pictures of completed docs to email in, please ensure photo is clear)

Injury/Fracture/Sickness/Critical Illness

Line of Credit Protection Program #**LOC001-CM01**

Canadian Premier Life Insurance Company
C/O Premium Services Group Inc.
495 Richmond St., Suite 300, London, ON, N6A 5A9
FAX 1-888-341-4888

Section 1 - CLAIMANT'S STATEMENT

(To be completed by the Insured/Claimant - Please Print Clearly)

Reason for Claim: ☐ Injury/Fracture ☐ Sickness ☐ Critical Illness

Information about Insured/Claimant

Name _____
(Last) (First) (Init)

Claimant Email: _____

(In order to process your claim as efficiently as possible, most written communication is sent via email. Please ensure you check all mailboxes for emails from the domains @**premiumservicesgroup.ca** (eg. **claims@premiumservicesgroup.ca**)

Address _____
(Number, street, apartment number) (City) (Prov.) (Postal code)

Telephone No. (_____) _____ Sex ☐ M ☐ F Date of Birth (mm/dd/yyyy) _____

Name of Employer at Time of Loss _____

Information about your Injury/Sickness

Date Injury/Sickness occurred (mm/dd/yyyy) _____ Place of Accident: _____

Describe fully how the accident occurred _____

Describe your Injury/Sickness _____

Name of your employer _____

Name of your Physician _____ Telephone No. _____

Prior History of the Same or Related Illness ☐ No ☐ Yes (describe) _____

CLAIMANT'S CERTIFICATION: The above statements are true and complete to the best of my knowledge and belief.

PRIVACY NOTICE: The information provided on this claim form and otherwise in respect of this claim, is required by Canadian Premier Life Insurance Company, its reinsurers and authorized administrators (the "Insurer") to assess this claim. For these purposes, the Insurer will also consult its existing insurance files, collect additional information from the claimant and where required, collect information from and exchange information with, third parties. Limited information related to the status of the claim and the amount of the debt will be exchanged with the creditor who is the beneficiary under this plan, strictly for the purpose of administering insurance benefits. Medical information will not be provided to the creditor without an additional specific authorization to that effect.

AUTHORIZATION: I authorize, for a period of not more than twenty-four months from the date hereof, any employer, physician, practitioner, health care professional, hospital, health care institution, and any other medical or medically related facility, any insurance or reinsurance company, Workers' Compensation Board, HRDC or similar plan or organization, federal, territorial or provincial government department, or any other corporation or organization, institution or association possessing records or knowledge of me to release and exchange with Canadian Premier Life Insurance Company, or representatives thereof, all personal health information, benefit payment, employment or financial information about me or in its possession that is requested while administering this claim. A photocopy or facsimile of this authorization is as valid as the original. I have provided my personal email address above for the purpose of receiving communication regarding this claim. I give Canadian Premier Life Insurance Company and its representative's permission to communicate the details about this claim using the email address provided.

I understand why I have been asked to disclose this information and the risks and benefits of consenting or refusing to consent. I understand that I can withdraw my consent at any time, but that if I do, the Insurer will not be able to assess my claim and will not pay benefits.

Claimant's Name _____ Signature _____ Date Signed _____

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Section 2 - EMPLOYER'S STATEMENT (Please Print Clearly)

Note to Claimant:

- **To be completed by your Employer only if you are unable to work for 10 consecutive working days due to Injury or Sickness.**

Employee Name _____
(Last) (First) (Init)

Reason for Employee's absence from work _____

Seasonal Employee ☐ Yes ☐ No *If Yes, provide total number of hours worked in the past 12 months: _____

Employee's first day worked (mm/dd/yyyy)_____

Employee's last day worked (mm/dd/yyyy)_____ Date Employee did or will return to work (mm/dd/yyyy)_____

Name of Employer _____

Employer's Address_____
(Number, street, unit number) (City) (Prov.) (Postal code)

Name of Authorized Official _____ Title of Authorized Official _____

Contact Telephone Number (_____) _____ Fax Number (_____) _____

Signature _____ Date Signed _____

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Section 3 - PHYSICIAN'S STATEMENT (Please Print Clearly) PAGE 1 of 2

Note to Claimant:

- To be completed by the family physician who has the medical records. If there is no family physician, then by the physician treating the current injury or sickness.

The Claimant/Patient is responsible for having this form completed and for any fees charged.

Patient's Name _____ Date of Birth _____
(Last) (First) (Init) (mm/dd/yyyy)

HISTORY

A) When did symptoms first appear or when did the injury occur? (mm/dd/yyyy) _____

B) Has the patient ever had the same or a similar condition? ☐ Yes (state when and describe below) ☐ No ☐ Unknown

_____

C) Is condition due to injury or sickness arising out of employment? ☐ Yes ☐ No ☐ Unknown

D) Name of any other treating physicians: _____

Address _____
(Number, street, unit number) (City) (Prov.) (Postal code)

DIAGNOSIS (Including any complications)

A) Primary Diagnosis _____ Date of Diagnosis (mm/dd/yyyy) _____

B) Secondary (if applicable) _____ Date of Diagnosis (mm/dd/yyyy) _____

C) Subjective Symptoms _____

D) Objective Findings _____
(x-rays, laboratory, EKG, clinical findings)

E) List any bones that were fractured: _____

For Critical Illness definitions, see page 2 of this section.

TREATMENT

A) Date of First Visit _____ Date of Last Visit _____
(mm/dd/yyyy) (mm/dd/yyyy)

B) Frequency of visits ☐ weekly ☐ monthly ☐Other - Specify: _____

C) Date of Hospitalization: Confined from (mm/dd/yyyy) _____ to (mm/dd/yyyy) _____

D) Nature of Treatment _____

E) Does the fracture indicated above require the following treatment(s): ☐ Fixation ☐ Metal Fixation ☐ Open Operation Grafting

Date of Treatment (mm/dd/yyyy) _____

REMARKS

Period during which patient was unable to work: From (mm/dd/yyyy) _____ to (mm/dd/yyyy) _____

Additional Comments/Information _____

_____ _____ _____ (____) _____
Signature of Physician Name Date Telephone

Address _____
(Number, street, unit number) (City) (Prov.) (Postal code)

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Injury/Fracture/Sickness/Critical Illness

Line of Credit Protection Program #**LOC001-CM01**

Critical Illness Definitions

Cancer (Life-Threatening)

Coverage: Defined as a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Excluded: Carcinoma in situ; Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without level IV or V invasion); any non-melanoma skin cancer that has not become metastatic (spread to distant organs); stage A (T1a or T1b) prostate cancer.

Heart Attack (Myocardial Infarction)

Coverage: Defined as the death of a portion of heart muscle as a result of inadequate blood supply as evidenced by:

1. New electrocardiographic (ECG) changes indicative of a myocardial infarction, and by
2. The elevation of cardiac biochemical markers to levels considered diagnostic for infarction.
3. Heart attack during coronary angioplasty is covered provided that there are diagnostic changes of new Q wave infarction on the ECG in addition to elevation of cardiac markers.

Excluded: Does not include an incidental finding of ECG changes suggesting a prior myocardial infarction, in the absence of a corroborating event.

Stroke

Coverage: Means an acute cerebral vascular accident (CVA), producing neurological sequelae lasting more than thirty (30) days and caused by thrombosis, hemorrhage, or embolism from an extra-cranial source. There must be evidence of measurable, objective neurological deficit.

Excluded: Transient Ischemic Attacks (TIAs) are not covered. TIA is a brief focal neurological deficit that resolves without any permanent neurological impairment.

Renal (Kidney) Failure

Coverage: Means end stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis, peritoneal dialysis or renal transplantation is initiated.

Major Organ Transplant & Major Organ Failure

Coverage: On waiting list-is "the Diagnosis of the irreversible failure of the heart, both lungs, both kidneys, or bone marrow.

Excluded: Transplantation must be medically necessary.

CASHMONEY®

Injury/Fracture/Sickness
Critical Illness Claim

What Happens Now?

Claim is Sent to PSG

- Claims are to be sent directly to PSG

Claim is Processed by PSG

- Once ALL required documents are received, claims processing takes 48-72 hours
- If any documents or supporting material is missing we will notify you and Cash Money by email

Claim is Approved by PSG

- **Critical Illness**: a benefit equal to the outstanding balance (up to the maximum indicated in the Certificate of Insurance) on the date of CI will be paid to Cash Money to be applied to your account

- **Disability:**
  - **Immediately:** an initial payment based on your payment mode, equal to 1 monthly, 2 bi-weekly or 4 weekly installments will be paid to Cash Money to be applied to your account
  - **Every 30 days:** You are required to present a copy of a doctor's note on their letterhead or employers statement every 30 days from the date you were disabled confirming you are unable to work.
    - Upon receiving acceptable proof of inability to work; an additional payment equal to your payment mode will be paid every 30 days for up to 6 months **subject to the benefit maximums** as indicated in the Certificate of Insurance.
    - Proof must be continuous, and provided within 90 days of the date required
    - You will not be required to provide confirmation of disability during the period in which the physician has indicated you will be unable to work on the claim form

Claim is Declined by PSG

- If your claim for benefits is declined, you will be contacted by PSG in writing.
- Should you wish to dispute any decision made by the insurer you may PSG.

IMPORTANT

Please note that you are required to make your line of credit payments while your claim is being adjudicated and until any benefit payments are received by Cash Money, in order to avoid additional interest and fees from accumulating. **Claim Benefits do NOT include any late penalty or arrears interest.**

Furthermore, if the completed documents are not received within the five (5) business days, we will assume that you have decided not to proceed with your claim and all late fees and interest will be accrued back to the date your last payment was due.

Claimant Signature: _____