IWS Creditor Group

Western LIFE ASSURANCE

Injury/Fracture/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(s) 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 the 'What Happens Now' section. Please read this section so you know exactly what to expect with your 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 three methods below:

Email: cashmoney@iwsinc.ca
Claims Fax Hotline: 1.888.341.4888
Mail: **IWS Creditor Group/Western Life Assurance**
300- 495 Richmond St.,
London ON N6A 5A9

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

Injury/Fracture/Sickness/ Critical Illness – Claims Package

Administration Office

IWS Creditor Group/Western Life Assurance
300- 495 Richmond St.,
London ON N6A 5A9

Claims Info Hotline: **1-866-210-1296**
Claims Fax Hotline: **1-888-341-4888**
Claims Email : cashmoney@iwsinc.ca
(For claims submission only)

Claim Information

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

Claims Contact: _____

Phone: _____

Claimant's Name: _____

Claim Checklist

(Please check boxes when completed)

Claim Form completed in full?	
Claim Form completed in full? ***(Doctor's/Employer's section completed)***	
Copy of loan documents outstanding on date of disability?	
If Injury is due to motor vehicle accident, please include Motor Vehicle Accident Report	
Additional Information? *(please note)*	

IMPORTANT

1. the administration office must be notified within **30 days** of your date of Injury/Illness/Fracture/CI
2. the completed claim form (*see checklist below*) must be submitted to the administration office within **90 days** of the date of your Injury/Illness/Fracture/CI

Submitted By:	
Customer	• Please ensure ALL documents are either emailed to cashmoney@iwsinc.ca ; faxed to number above or mailed to IWS Creditor Group. • Please watch for email confirmation from IWS 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

Loan Protection Program #CM01004

Western Life Assurance Company
C/O IWS Creditor Group
495 Richmond St., Suite 300, London, ON, N6A 5A9
(F) 1-888-341-4888 (E) cashmoney@iwsinc.ca

Section 1 - CLAIMANT'S STATEMENT

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

Reason for Claim: ☐ Injury/Fracture ☐ Sickness

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 @iwsinc.ca (eg. cashmoney@iwsinc.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 _____

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 Western Life Assurance Company, it's 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 less than twelve and 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 Western Life Assurance 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 Western Life Assurance 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

Injury/Fracture/Sickness/Critical Illness

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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)

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: _____

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)

Injury/Fracture/Sickness
Claims Payment Disclosure

What Happens Now?

Claim is Sent to IWS

- If claims are sent directly to IWS, IWS will provide confirmation of receipt of this claim to both Cash Money and yourself

Claim is Processed by IWS

- 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 CashMoney by email

Claim is Approved by IWS

- Once a file has been approved
- **Critical Illness:** a benefit equal to 100% of the outstanding balance on the date of CI
- **Disability:**
  - **Immediately:** 2 bi-weekly payments will be paid to CashMoney 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. Please send confirmation documents to cashmoney@iwsinc.ca or by fax to 1.888.341.4888 Attn. IWS/CashMoney Claims
    - Upon receiving acceptable proof of inability to work; 2 bi-weekly benefits will be paid every 30 days after proof is received until either a total of **12 Bi-weekly payments** have been paid on this claim, the maximum benefit of $2000 has been reached, or the loan has been paid off; whichever comes first.
    - 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; you are required to call in and notify IWS you are still unable to work. IWS will indicate the details of this process on any emails to you outlining claim benefits detail.

Claim is Declined by IWS

- If your claim for benefits is declined, you will be contacted by both CashMoney by phone and Western Life/IWS in writing.
- Should you wish to dispute any decision made by the insurer you may contact IWS directly at 1.855.377.7542.

IMPORTANT

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

Furthermore, completed documents should be received within the five (5) business days, to ensure that your claim can be processed as soon as possible and no unnecessary interest and late fees are accrued.

Claimant Signature: _____