

**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 to Canadian Premier’s authorized administrator using any of the three 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

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

**Authorized Administrator for Canadian Premier Life**

**Premium Services Group**  
 300- 495 Richmond St.,  
 London ON N6A 5A9

Claims Info: **1-855-755-2430ext. 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 Form completed in full? <i>(Doctor's/Employer's section completed)</i>	
Copy of Line of Credit documents outstanding on date of disability?	
Additional Information? <i>(please note)</i>	

**IMPORTANT**

1. We must be notified at the offices of our authorized administrator, PSG, within **30 days** of your date of injury, sickness or critical illness
2. the completed claim form *(see checklist below)* must be submitted to PSG at the address indicated above within **90 days** of the date of your injury, sickness or critical illness

Submitted By:	Please Note
Customer	<ul style="list-style-type: none"> <li>• Please ensure ALL documents are faxed/emailed to the contact info above</li> <li>• Please watch for email confirmation from our authorized administrator, PSG, that file was received                      (If you are sending pictures of completed docs to email in, please ensure photo is clear)</li> </ul>



**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 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 \_\_\_\_\_

# Injury/Fracture/Sickness/Critical Illness

Line of Credit Protection Program #LOC001-CM01

## 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 \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Init) Date of Birth \_\_\_\_\_ (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) \_\_\_\_\_

i) Consultation Dates Leading to Diagnosis (list all): \_\_\_\_\_

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 \_\_\_\_\_ (mm/dd/yyyy) Date of Last Visit \_\_\_\_\_ (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/Critical Illness

Line of Credit Protection Program #LOC001-CM01

## Section 3 - PHYSICIAN'S STATEMENT

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### 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.

**Canadian Premier Life Insurance Company**  
**Injury/Fracture/Sickness/Critical Illness Claim**

**What Happens Now?**

**Claim is Sent to Canadian Premier's Authorized Administrator: PSG**

- Claims are to be sent directly to PSG
- PSG will send email confirmation to both Cash Money and Customer. Please ensure confirmation is received within 24 hours. If not, please resend file or contact 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 you will be notified by email

**Claim is Approved**

- **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 of the **Monthly Amount Insured** 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

**Claim is Declined**

- If your claim for benefits is declined, you will be contacted in writing.
- Should you wish to dispute any decision made you may contact Canadian Premier's administrator, PSG at 1-855-755-2430

Please note: If you have any concerns with the handling of your claim or other related matters of service or concern, you may contact Canadian Premier Life Insurance Company directly at the contact information below or at 1-800-763-1300 or online at <https://www.canadianpremier.ca/complaints/>

**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: \_\_\_\_\_