P.O. Box 4241, Station A
Toronto, ON M5W 5R3
ivari.ca

*Critical*ADVANTAGE™ Claimant's Statement

If someone other than the claimant has completed this form or part of this form, please give full name and relationship to claimant:

_____

Claimant's Information

Last name	First name		Date of birth (DD/MM/YYYY)
Address			Apt./suite #
City	Province/territory/state	Country	Postal/zip code
Home phone	Mobile phone	Business phone	Policy number
Email address	Occupation	Industry*	Last date worked (DD/MM/YYYY)

*For a list, click ***Valid industries and occupations form (IP-LP1971)*** to access.

Details of Condition

1. On what date did symptoms begin? (DD/MM/YYYY) _____
   Describe your symptoms: _____
2. On what date were you advised of the diagnosis? (DD/MM/YYYY) _____
3. If claiming for a **surgical procedure**, on what date did the surgery take place? (DD/MM/YYYY) _____
4. Please give dates and describe the onset and nature of your condition: _____
5. On what date did you first consult a doctor for this condition? (DD/MM/YYYY) _____
6. What is the name and address of the doctor? _____
7. Was this your usual medical attendant? ○ Yes ○ No
   If ***"no,"*** who referred you to this doctor? _____
8. What tests were conducted to diagnose your condition? _____
9. What is your current treatment and on what date did it begin? _____
10. Have you previously suffered from, or received treatment for, a similar or related condition? ○ Yes ○ No
    If ***"yes,"*** give full details and dates for each episode: _____

11. Have any of your blood relatives suffered from a similar or related illness? ○ Yes ○ No

    If ***"yes"***, state relationship of relative, nature of illness and the age and year at which the illness was diagnosed:

12. Have you had any HIV Tests? ○ Yes ○ No

    If ***"yes"***, please provide latest date: (DD/MM/YYYY) _____ Result: ○ positive ○ negative

    If ***"no"***, has one been scheduled? ○ Yes ○ No

    If ***"yes"***, please provide date: (DD/MM/YYYY) _____

13. a) Do you use nicotine products? ○ Yes ○ No

    If ***"yes"***, describe the type, your daily consumption and state how long you have been using them:

    b) If ***"no"***, have you ever used nicotine products, and if so what was your daily consumption and when did you stop?

14. Please give names, addresses and telephone numbers of all physicians who have treated you or hospitals at which you have been treated for this condition.

NAME OF DOCTOR	ADDRESS (NUMBER, STREET, CITY, PROVINCE/TERRITORY/STATE)	TELEPHONE NO. INCLUDING AREA CODE	DATES SEEN (DD/MM/YYYY)

NAME OF HOSPITAL	ADDRESS (NUMBER, STREET, CITY, PROVINCE/TERRITORY/STATE)	TELEPHONE NO. INCLUDING AREA CODE	ADMISSION DATE (DD/MM/YYYY)	DISCHARGE DATE (DD/MM/YYYY)

15. If not already provided above, please give the name, address and phone number of your family physician in Canada:

16. Are you insured for benefits related to this condition from another company? ○ Yes ○ No If ***"yes"***, please indicate:

NAME OF INSURER	POLICY NUMBER	TYPE OF BENEFIT	AMOUNT OF BENEFIT INSURED	HAS A CLAIM BEEN SUBMITTED?
			$	○ Yes ○ No
			$	○ Yes ○ No
			$	○ Yes ○ No

Notice regarding collection, use and disclosure of personal information – (Privacy Notice)

ivari's Privacy Policy, available at **ivari.ca,** tells you how ivari will handle your personal information as an Insured and/or Claimant. It also tells you about your rights and choices.

In summary:

ivari uses your personal information for the following purposes:

- Verifying your identity;
- Evaluating any forms you submit about the insurance policies you have in place with ivari;
- Administering and servicing the policy;
- Supporting business operations necessary for us to service the policy;
- Conducting investigations and analyzing claims; and
- Complying with our legal and regulatory obligations (such as tax reporting, compliance with anti-money laundering and anti-terrorist financing laws, and prudential and market conduct laws) and/or any legal or regulatory orders (for example, a court order, subpoena) against ivari.

When required as part of our claims analysis, we may also collect your personal information from external sources such as health care facilities or providers, investigative agencies and/or consumer and credit reporting agencies, and others.

When required, ivari may share your personal information with trusted third parties, including service providers retained by ivari to assist in administering ivari policies, ivari's reinsurers; your financial institution, your independent insurance advisor and their supporting associates, market intermediaries, your beneficiaries and assignees, your family physician or treating medical practitioner and other insurance companies to whom a claim for benefits may be submitted.

It is possible that your personal information may be transferred, stored, handled, or processed outside your jurisdiction and that authorities in those jurisdictions may have access to it.

In some cases, you have a **right to withdraw consent** to the use and sharing of your personal information. You also have the **right to see and correct** the information we have about you, and to **obtain information about any fully automated decisions** we make using your information. Mail your written request to: **Chief Privacy Officer, ivari, 200-5000 Yonge Street, Toronto, Ontario M2N 7E9 or email: privacyoffice@ivari.ca.**

You can see ivari's full Privacy Policy online at ivari.ca. Please make sure you read it carefully so that you understand it in full. Please note that we may update this Privacy Policy from time to time.

CONSENT REQUIRED FOR THIS FORM AND POLICY

The following consents are required to proceed with and submit this form to ivari:

1. I give my consent to the collection, use and disclosure of my personal information as described in the **Privacy Notice** and in ivari's Privacy Policy on **ivari.ca.**
2. I authorize ivari to collect my personal information from third parties for the purposes described in and in accordance with ivari's Privacy Policy.
3. If I am giving my consent on behalf of one or more minor Insured(s) (under the age of 18 years in Quebec or under the age of 16 years in all other provinces) to the points above, then I represent that I have authority to consent on behalf of the minor Insured(s).

Signature of **Insured** Signature of **Claimant**

Declaration and Authorization

Claimant's Certification: The statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, the policy can be voided, payment of benefits denied and past claims payments recovered. I hereby agree to refund to ivari, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim for benefits.

This authorization does not have any expiry date and it will remain valid for as long as I am claiming eligibility for benefits or services from ivari. I, the undersigned, agree that a photocopy or electronic copy of this authorization as executed by me will be as valid as the original.

Insured name	Signature of Insured	Date (DD/MM/YYYY)
Claimant name	Signature of Claimant	Date (DD/MM/YYYY)
Relationship to the Insured		

P.O. Box 4241, Station A, Toronto, ON M5W 5R3 • Telephone: 1-855-806-5057 • **claimsdepartment@ivari.ca**

The fastest and easiest way to send us your completed and signed forms is through our online tool, *Send documents* on ivari.ca. By using this tool, forms are sent instantly and securely.

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