Canada Life

Bank of Nova Scotia

Life Claim Form

Canada Life

Creditor Life Insurance Claim Form

Once your claim has been received by Canada Life, a claims specialist will be assigned to your file. He or she will assess the information provided, request more information where necessary and determine benefit eligibility.

In order for this process to be as efficient as possible, it is very important for you to fully complete the claim form and attach all required information. The claims specialist is not able to make a decision until all information has been provided and verified.

If you have any questions about your claim, please call our Customer Service toll-free hotline at 1-800-387-2671.

General Instructions:

1. Complete all sections of the form prior to submission to Canada Life.
2. Be sure to sign and date the form.
3. Submit your claim to Canada Life in the enclosed return envelope or fax to (902) 423-8169.

Complete information about the deceased.

Information About the Deceased

Name of deceased: Sex: __ Male __ Female	Surname	First Name	Initial
Address of deceased (name and street number)			Date of Birth (DD/MM/YY)
City	Province	Postal Code	Date of Death (DD/MM/YY)

Please provide the type of lending product and group number.

Loan Details (Attach additional form if more than 3 loans)

	Loan 1	Loan 2	Loan 3
Lending Product. Please specify type: Mortgage, Personal Loan, Commercial Credit, ScotiaLine:			
Mortgage, Personal Loan, Commercial Credit, ScotiaLine **Number:**			

To be completed in full by the Deceased's Authorized Representative (next-of-kin, executor, etc.)

Deceased's Authorized Representative Statement

By signing here, you authorize The Canada Life Assurance Company:

To obtain, collect and exchange personal information with personal information agencies and investigation agencies, other insurers, medical practitioners and institutions having relevant personal information about the Insured and persons who perform medical services for The Canada Life Assurance Company to provide and exchange my personal information required to process a claim relating to the Bank of Nova Scotia insurance.

You also authorize all physicians, hospitals, clinics, dispensaries, sanatoriums, druggists, employers and all other agencies to provide a copy of the Insured's medical and employment records to The Canada Life Assurance Company in order to process a claim relating to the Bank of Nova Scotia insurance.

You acknowledge that a photographic copy of this authorization is as valid as the original.

Relationship to Deceased (e.g. next-of-kin, executor, executrix, etc):			
Name of Deceased's Authorized Representative	Surname	First Name	Initial
Address (name and street number)			
City	Province	Postal Code	
Telephone No. ( )	Fax No. ( )		
Signature of Authorized Representative			Date D D M M Y Y

Please provide information of the Deceased's General Practitioner

General Practitioner of the Deceased

Name of Deceased's General Practitioner	Surname	First Name	Initial
Address of physician (name and street number)			
Telephone No. ( )	Fax No. ( )		

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The Deceased's Attending Physician to complete this section in full.

This section to be filled out by the Attending Physician

Note: Any charge for completing this form is the responsibility of the claimant.

Name of Deceased	Surname	First Name	Initial

Date of Birth	Date of Diagnosis	Date of First Treatment for Conditions causing death	Date of Last Treatment	Date of Death
D D M M Y Y	D D M M Y Y	D D M M Y Y	D D M M Y Y	D D M M Y Y

Primary Cause of Death :	
Secondary Cause:	

If death by ☐ Accident ☐ Suicide (Please tick appropriate box and provide additional details)

Was inquest held? ☐ Yes ☐ No If yes, by whom and what were the findings?

List any conditions for which you treated the deceased during the 24 month period prior to:

Effective Date of Coverage
D D M M Y Y

Date	Diagnosis	Treatment Prescribed	Type of Surgery

Name and address of any other doctor(s) who saw the deceased during period noted above. If none please indicate:

Name and Address(es)	Specialty
1.	
2.	

Information about the Physician competing this form.

Name of Physician	Specialty

Address (name and street number)

City | Province | Postal Code

Telephone No.	Fax No.
( )	( )

These statements are true and complete to the best of my knowledge

Signature:

Date
D D M M Y Y

Where to send claim form(s)

Submit all completed documents to:	THE CANADA LIFE ASSURANCE COMPANY CREDITOR INSURANCE CLAIMS DEPARTMENT PO Box 158, STN M, Halifax, NS B3J 3V2 TOLL FREE: 1-800-387-2671 FAX: (902) 423-8169, Toll Free Fax: 1-844-223-2766

Note: Unless specified the word "LOAN" will refer to any personal loan, commercial credit, mortgage or ScotiaLine.