

SCOTIA CREDIT CARD PROTECTION DISABILITY CLAIM

Please be advised that minimum payments must continue to be remitted to the credit card account.

INSTRUCTIONS FOR COMPLETION OF THIS CLAIM PACKAGE

***** PLEASE NOTE: IF YOUR LOSS OCCURRED PRIOR TO OCTOBER 17, 2020, THE EMPLOYMENT ELIGIBILITY REQUIREMENT IS 180 DAYS.**

IF YOUR LOSS OCCURRED ON OR AFTER OCTOBER 17, 2020 THE EMPLOYMENT ELIGIBILITY REQUIREMENT IS 90 DAYS.***

FOR LOSS THAT OCCURED ON OR AFTER OCTOBER 17, 2020 AND PRIOR TO APRIL 1, 2024: In order to be eligible for these benefits You must be totally disabled from performing the essential duties of Your job because of a sickness, injury, mental illness or nervous disorder for a period of at least 30 consecutive days. You must have been employed for at least 90 consecutive days and working at least 20 hours per week immediately before your period of disability. For those enrolled in Post-secondary Education and have experienced a loss on or after March 11, 2020, the number of employment hours required each week is 10. The hours work requirement is continuous and must not be calculated through averaging.

FOR LOSS THAT OCCURRED ON OR AFTER APRIL 1, 2024: In order to be eligible for these benefits, it has been determined by Your Doctor that You are prevented by any medical condition from performing Your normal activities of daily living or the regular duties of Your employment or self-employment, as applicable, for a period of at least 30 consecutive days.

Any benefit payable under any one of the insured events shall not be payable under another insured event for the same cause. If the Claimants are eligible concurrently for a benefit payable for more than one insured event covered by this Certificate, the benefit paid shall be limited to the highest amount. The Claimants shall therefore be entitled to only one benefit at a time.

If you wish to claim under multiple credit cards - please complete just one claim form package. You can enter the applicable credit card number(s) in the form below.

In order for us to review your claim for eligibility, you must provide ALL of the following:

1. The enclosed Claimant Statement form fully completed and signed by the Claimant.
2. a) The enclosed Employer Statement form fully completed and signed by the Employer and copy (or copies) of your Record(s) of Employment (ROE) – supporting you worked at least 90 consecutive days. **If you cannot obtain the completed Employer Statement, please complete the details in the form as best as possible and provide ROE(s).** (*Requirements only applicable for a loss that occurred prior to April 1, 2024*)

b) **If Self-Employed:** The enclosed Self- Employed Statement form fully completed and provide proof of self-employment/income for 90 consecutive days up to the date you became disabled. (*Requirements only applicable for a loss that occurred prior to April 1, 2024*)
3. The enclosed Attending Physician Statement form fully completed and signed by the Attending Physician or Specialist along with any applicable test results.
4. A copy of the Scotia Credit Card Statement:
 - Issued in the month your disability commenced
 - Issued the month immediately after your disability commenced
 - In addition - Please provide original receipts for any purchases made prior to your date of disability but not yet appearing on your credit card statement.

If you do not have these statements, copies can be requested through your local Scotiabank branch or Scotiabank Centre. These copies must accompany the claim forms you are submitting to us.

Failure to submit ALL of the required information as outlined above will result in a delay in your claim.

PLEASE SUBMIT ALL COMPLETED CLAIM FORMS AND CLAIM INFORMATION BY MAIL, EMAIL OR BY FAX TO UNITY MANAGING UNDERWRITERS LIMITED.

Unity Managing Underwriters Ltd. is acting as a Third Party Administrator (“TPA”) handling these claims on behalf of Chubb Insurance or Chubb Life Insurance Company of Canada.

MAIL:

Unity Managing Underwriters Ltd.
P.O. Box 1097, Station B
Willowdale, Ontario, M2K 3A2

EMAIL: SCCPClaims@umu.net

FAX: 416-221-1685

Scotia Line of Credit Insurance: Please note that Chubb Life Insurance Company of Canada does not administer benefits for **Scotia Line of Credit Insurance Protection**. If you wish to submit a claim for your Line of Credit account, please contact Scotiabank at 1-855-753-4272.



**SCOTIA CREDIT CARD PROTECTION CLAIM FORM
DISABILITY
CLAIMANT STATEMENT**

Unity Managing Underwriters Ltd.
P.O. Box 1097, Station B
Willowdale, Ontario, M2K 3A2
T +1.800.668.7092
F +1.416.221.1685
E SCCPClaims@umu.net

Employment Requirements only applicable for a loss that occurred prior to April 1, 2024

THIS SECTION TO BE COMPLETED BY THE INSURED			
Title:	Name:	Scotia Credit Card No.:	
Additional Scotia Credit Card No(s):			Reference No:
Phone #:		Email Address:	
Address:			
City:	Province:	Postal Code:	Date of Birth: (MM/DD/YYYY)
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		Date of Disability: (MM/DD/YYYY)	
Date Symptoms first started: (MM/DD/YYYY)		Disabling Condition:	
If accident, state when, where and how:			
Date first unable to work: (MM/DD/YYYY)		Date of first medical attendance: (MM/DD/YYYY)	
Date returned to work: (MM/DD/YYYY)		Date of expected return to work: (MM/DD/YYYY)	
Have you had same or similar condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:			
Name of Physician:		From: (MM/DD/YYYY)	To: (MM/DD/YYYY)
Address:			
Name of Physician:		From: (MM/DD/YYYY)	To: (MM/DD/YYYY)
Address:			
Name of Hospital (In Patient):		From: (MM/DD/YYYY)	To: (MM/DD/YYYY)
Address:			
Have you applied for or are you receiving? <input type="checkbox"/> C.P.P./Q.P.P. <input type="checkbox"/> Employer Disability <input type="checkbox"/> Automobile Ins. <input type="checkbox"/> W.C.B./W.S.I.B. <input type="checkbox"/> Other (Specify):			

Please confirm you have included a copy of the following documents in addition to this form in your claim submission package: (see Instruction Sheet for more information): ***Employment Requirements only applicable for a loss that occurred prior to April 1, 2024**

- *COPY OF RECORD OF EMPLOYMENT – Supporting you worked at least 90 consecutive days
- *ENCLOSED EMPLOYER STATEMENT – If Self-Employed – see below.
- ENCLOSED ATTENDING PHYSICIAN STATEMENTS AND APPLICABLE MEDICAL RECORDS
- COPY OF SCOTIA CREDIT CARD STATEMENTS:
 - Issued in the month your disability commenced
 - Issued in the month immediately after your disability commenced
- Please provide original receipts for any purchases made prior to your date of disability but not yet appearing on your credit card statement.

SELF-EMPLOYED PERSON – In addition to the above – please complete/provide the following:

- *ENCLOSED SELF-EMPLOYED STATEMENT
- *If you are self-employed, please provide proof of self-employment/income for 90 consecutive days up to the date you became disabled.

Claimant's Certification: The above 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, coverage can be cancelled, payment of benefits denied and past claims payments recovered without refund of any premiums paid. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

Privacy Notice: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Chubb Insurance and/or Chubb Life Insurance, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. The Insurer will establish a claims file to which access will be restricted to authorized employees and agents of the Insurer and to persons authorized by law. If I have the right to access the information, access will be given to me or such persons as I may authorize. I understand that in some instances, the employees, service providers, agents, reinsurers, and any of their providers, of Chubb may be located in jurisdictions outside Canada and my personal information may be subject to the laws of those foreign jurisdictions. I consent to the collection, use, and distribution of my personal information as may be required for these purposes as of the date of signing of this Claimant Statement and understand that such consent will remain in place until such time as I may revoke it.

To find out more about the Chubb Privacy Policy or our privacy practices please visit chubb.com/ca or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.

Authorization: I authorize any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers' compensation board or similar plan or organization, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Chubb Insurance/Chubb Life Insurance, or representatives thereof, all personal health information, benefit payment or financial information about the insured or any other information or records about the insured in its possession that is requested while administering this claim. This authorization shall be valid until withdrawn. I understand that I may revoke my consent and authorization at any time.

I agree that a photocopy of this authorization shall be as valid as the original.

Claimant's Signature: _____ Date (MM/DD/YYYY): _____

By completing and submitting this form, I agree to all the declarations and attestations made herein. Please submit this form via email to SCCPClaims@umu.net

IMPORTANT:

Note that until this claim is approved you remain responsible for making the minimum payment to your account. You are responsible for the minimum payment due resulting from any purchases made after your date of disability.



**SCOTIA CREDIT CARD PROTECTION CLAIM FORM
DISABILITY
EMPLOYER STATEMENT**

Unity Managing Underwriters Ltd.
P.O. Box 1097, Station B
Willowdale, Ontario, M2K 3A2
T +1.800.668.7092
F +1.416.221.1685
E SCCPClaims@umu.net

Employment Requirements only applicable for a loss that occurred prior to April 1, 2024

EMPLOYER STATEMENT – TO BE COMPLETED BY EMPLOYER OF THE CLAIMANT:

THIS SECTION TO BE COMPLETED BY THE EMPLOYER		
Name of Employee:		
Occupation:		
Date of Hire: (MM/DD/YYYY)	Hours Worked/Week:	
Last Day Worked (Prior to Sick Leave): (MM/DD/YYYY)		
Company:		
Employer's Name:	Your Position:	
Address:		
City:	Province:	Postal Code:
Phone #:	Fax #:	
Email Address:		
I _____ hereby declare that the above information concerning _____ is true to the best of my knowledge. (employer's name) (employee's name)		

Employer's Signature: _____ Date (MM/DD/YYYY) : _____

By completing and submitting this form, I agree to all the declarations and attestations made herein. Please submit this form via email to SCCPClaims@umu.net



**SCOTIA CREDIT CARD PROTECTION CLAIM FORM
DISABILITY
SELF-EMPLOYED STATEMENT**

Employment Requirements only applicable for a loss that occurred prior to April 1, 2024

THIS SECTION TO BE COMPLETED BY THE SELF-EMPLOYED CLAIMANT		
Self-Employed Claimant's Name:	Business Registration No:	
Name of Business:	Occupation:	
Effective Date of Business Registration: (MM/DD/YYYY)	Hours Worked/Week:	
Last Day Worked (Prior to Sick Leave): (MM/DD/YYYY)		
Business Address:		
City:	Province:	Postal Code:

Business Owner/Self-Employed Signature: _____ Date (MM/DD/YYYY) : _____

By completing and submitting this form, I agree to all the declarations and attestations made herein. Please submit this form via email to SCCPClaims@umu.net



SCOTIA CREDIT CARD PROTECTION CLAIM FORM
DISABILITY
ATTENDING PHYSICIAN'S STATEMENT

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E SCCPclaims@umu.net

THE PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND FOR CHARGES MADE FOR ITS COMPLETION

Physician's Name:		
Address:		
City:	Province:	Postal Code:
Phone Number:	Fax Number:	
Patient's Name:		Date of Birth: (MM/DD/YYYY)
Primary Diagnosis:		
Secondary Diagnosis (if applicable):		
Symptoms associated with diagnosis:		
If appropriate – additional conditions which might affect the duration of disability:		
Has Patient had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes", state when and describe:		
Is condition due to injury arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If accident, please provide brief description:		
Was Patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Hospital:		
Date of Hospital Admission: (MM/DD/YYYY)		Date of Discharge: (MM/DD/YYYY)
If surgery performed, please provide date and describe: (MM/DD/YYYY)		
If referred to you, give name of referring physician:		
Date of first visit for present period of disability: (MM/DD/YYYY)		
Date of latest attendance: (MM/DD/YYYY)		
Were you actively supervising this patient's care during the full period? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes", state frequency of visits. <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify):		
If condition is due to pregnancy, what is (or was) the expected date of delivery? (MM/DD/YYYY)		



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TOTALLY DISABLED

To the best of my knowledge, the patient has been Totally Disabled (Unable to work or perform normal activities of daily living):	
From: (MM/DD/YYYY)	To: (MM/DD/YYYY)
If still disabled, give approximate DATE when patient should be able to return to work or perform normal activities of daily living: (MM/DD/YYYY)	
Or, if indefinite, the estimated number of additional WEEKS before return of normal activities:	

PARTIALLY DISABLED

How long was or will patient be Partially Disabled?	
From: (MM/DD/YYYY)	To: (MM/DD/YYYY)
How does present condition affect patient's ability to work or perform normal activities of daily living?	

Physician's Signature: _____ Date (MM/DD/YYYY): _____

By completing and submitting this form, I agree to all the declarations and attestations made herein. Please submit this form via email to SCCPClaims@umu.net

THE PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND FOR CHARGES MADE FOR ITS COMPLETION