

Please PRINT clearly.

Securian Canada is committed to keeping your information confidential.

1. General information

Student information

Student's last name	Middle initial	First name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd-mm-yyyy)
Policy number(s)		Student ID number		
Residence address (street number and name)				Apartment or suite
City		Province	Postal code	
Country	Telephone		Preferred language of correspondence <input type="checkbox"/> French <input type="checkbox"/> English	

2. Disability due to sickness or injury

a) Please describe the nature of your condition:

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b) When did you first receive treatment from a physician?

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c) When were you first unable to attend classes?

Date (dd-mm-yyyy)	Time	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
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3. Treatment

a) Please provide the name and address of each physician or other health care provider involved in your medical care.

Last name		First name		Specialty
Date of last visit (dd-mm-yyyy)		Frequency of visits		Date of next visit (dd-mm-yyyy)
Address (street number and name)				Apartment or suite
City	Province		Postal code	Telephone
Last name		First name		Specialty
Date of last visit (dd-mm-yyyy)		Frequency of visits		Date of next visit (dd-mm-yyyy)
Address (street number and name)				Apartment or suite
City	Province		Postal code	Telephone

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3. Treatment (continued)

b) Please describe your current treatment (i.e. surgery, physiotherapy, counselling).

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c) If you are taking any prescription or over-the-counter medications, please provide the following details:

Name of medication	Dosage	Date started (dd-mm-yyyy)	Purpose of medication
Name of medication	Dosage	Date started (dd-mm-yyyy)	Purpose of medication

d) If you are scheduled for any further referrals, blood tests, x-rays, examinations, surgery, or any other type of investigation or treatment, please provide details here.

Type of referral, investigation or treatment	Date scheduled (dd-mm-yyyy)	Healthcare provider or facility
Type of referral, investigation or treatment	Date scheduled (dd-mm-yyyy)	Healthcare provider or facility

e) Overall, how would you most appropriately describe your current condition?

☐ Recovered ☐ Improved ☐ Unchanged ☐ Deteriorating

Please list and comment on only the symptoms which affect your ability to attend classes.

Specific symptom	If applicable, please comment on location, duration, frequency and severity of this symptom

4. Returning to college or university

a) Have you returned to college or university part-time?

☐ Yes ☐ No

If yes, when?

Date (dd-mm-yyyy)

b) Have you returned full-time (attending all classes)?

☐ Yes ☐ No

If yes, when?

Date (dd-mm-yyyy)

c) If you have not returned, what are your current thoughts about your readiness to do so?

☐ I do not anticipate returning on either a part-time or full-time basis

☐ I anticipate returning part-time on or around this date:

Date (dd-mm-yyyy)

☐ I anticipate returning full-time on or around this date:

Date (dd-mm-yyyy)

Please provide any other information that would be helpful in the assessment of your claim.

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Please attach to this claim form receipts for your book purchases as well as fees/expenses that are mandatory, non-negotiable and non-refundable and that you no longer use following withdrawal from college or university.

5. Declaration and authorization

I certify that the information provided for the claim(s) being submitted is true, accurate, and complete and that I, my spouse or co-applicant and/or my dependents have received all goods or services or qualify for benefits as claimed. I understand and acknowledge that submission of a claim determined by Securian Canada to be false or misrepresented may result in coverage being rescinded by Securian Canada without further notice. I understand and acknowledge that Securian Canada may refer any claims it has determined were falsely submitted to law enforcement authorities for possible prosecution and may pursue the recovery of any money obtained improperly through false claim submission. I also agree to refund any monies or overpayments that I may owe to Securian Canada in accordance with the provisions of my coverage and I authorize Securian Canada to deduct such monies from my future claims. I authorize any person or organization with information about me or my family members to collect, use, maintain, and exchange this information with each other and with Securian Canada, STUDENTCARE, or Securian Canada's service providers to administer my plan, audit or assess my claims. This includes medical and health professionals, facilities, providers, regulatory bodies, insurers, investigators, and administrators of other benefits programs. I also agree that I acknowledge that benefits are not payable for items that Securian Canada deems to be greater than usual, reasonable, and customary, or charges for devices that don't appear on Securian Canada's list of approved devices. I agree that a photocopy, facsimile, or electronic version of this authorization shall be as valid as the original. If applicable, I authorize Securian Canada to use the email address provided as a means of communication with me related to my Individual Insurance health care coverage. I agree that Securian Canada is not liable for damages which I may have incur as a result of interception by a third party or an email transmission sent by Securian Canada or by me pursuant to this authorization. I agree that should the email address identified on this form change, I am responsible for updating the email address maintained by Securian Canada.

Student's last name	First name
Student's signature X	Date (dd-mm-yyyy)

To avoid delays in processing your claim, please ensure that all sections of this application have been completed thoroughly.

6. Mailing instructions

Mail your complete form to:

Securian Canada
Box 963 Stn A,
Toronto, ON, Canada M5W 1G5

7. Respecting your privacy

Respecting your privacy is a priority for Securian Canada. We collect information from application forms and other information you provide to us or our distribution partners in connection with insurance and/or financial products offered by us, as well as (with your consent) through independent medical or vocational assessments, if applicable, and from physicians, medical practitioners, hospitals, clinics or other medical or medically related facilities, insurance companies, MIB, LLC. ("MIB"), and other agents, governments agencies or other organizations, institutions, or persons that have health records, if applicable. We collect, use and disclose your personal information for purposes that include: confirming your identity, underwriting, including determining your eligibility or need for insurance and/or financial products you request; administration and servicing; claims adjudication; protecting against fraud, errors or misrepresentations; and meeting legal, regulatory or contractual requirements. We, and our affiliates, may use the personal information for the purpose of offering you, or allowing select organizations to offer you, other products and services. You may withdraw your consent for this purpose at any time by phone at: 1-888-968-4155 or by mail at: Privacy Office, 25 Sheppard Avenue West, Suite 1400 Toronto, ON M2N 6S6. We will give access to your personal information only to those of our employees and independent contractors, affiliates within our corporate group, administrators, distribution partners, and other third-party service providers and outsourcers, along with our reinsurers, who need your personal information to do their jobs. We will also provide access to anyone else you authorize. All of our service providers with whom we have a contractual relationship are required to protect your personal information in accordance with this privacy statement and our privacy practices. Sometimes, unless we are otherwise prohibited, these people may be in, or your personal information may be stored on servers located in, other provinces in Canada or in countries outside Canada, so your personal information may be subject to the laws of those other provinces or countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit <http://www.securiancanada.ca/privacy-statement>.