HEALTH ASSOCIATION NOVA SCOTIA

CLAIMS NOTIFICATION
CRITICAL ILLNESS
POLICY# 87916

The Critical Illness benefit is payable if one of the following conditions is diagnosed: **Alzheimer's Disease, Aortic Surgery, Benign Brain Tumor, Blindness, Cancer (Life-Threatening), Coma, Coronary, Artery Bypass Surgery, Deafness, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Limbs, Loss of Speech, Major Organ Failure and On Waiting List for Transplant, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Occupational HIV Infection, Paralysis, Parkinson's Disease, Severe Burns, and Stroke (Cerebrovascular Accident).**

Coverage is also available for your dependent children. In addition to the previously listed adult illnesses, the following childhood conditions are covered: **Autism, Cerebral Palsy, Congenital Heart Disease (certain conditions apply), Cystic Fibrosis, Down Syndrome, Muscular Dystrophy, and Type 1 Diabetes Mellitus**.

Written notice and proof of loss must be submitted to Manulife Financial within ninety (90) days after the date of diagnosis. The claimant must survive 30 days from the date of diagnosis in order to receive this benefit. Please see Plan Documents for more details.

Failure to furnish such notice or proof within such time shall not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as was reasonably possible, but in no event later than one (1) year after the date of the diagnosis.

Employee Information

Last Name	First Name	Middle Initial	Certificate #
Date of Birth (MM/DD/YYYY)	Address		
City	Province	Postal Code	Telephone Number

Claimant Information

Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YYY)
Relationship to Employee ☐ Employee ☐ Spouse ☐ Dependent	Address		
City	Province	Postal Code	Telephone Number
Amount of Insurance $	Date of Diagnosis or Surgery (MM/DD/YYYY)		
Description of Diagnosis or Surgery			

To be Completed by Employee

Date (MM/DD/YY)	Signature of Employee

To be Completed by Employer

Division Name	Division Number	Location
Name of Contact Person (please print)		Date (MM/DD/YYYY)
Signature of Contact Person		