Processing your claim

Step by step

NATIONAL BANK INSURANCE

Summary

What you need to know...

Now that you're submitting a claim

Some time ago, you (or the deceased person whose estate you are settling) made the wise decision to purchase insurance for your peace of mind and your loved ones. Circumstances now require you to take advantage of this insurance.

If this is your first time submitting a claim, you may have some questions about the steps involved in processing it.

This document provides a quick and easy to understand overview of the claim settlement process. It contains:

- A description of the documents to submit for the various types of claims;
- The steps involved in examining your claim;
- A glossary of frequently used terms;
- Answers to frequently asked questions about insurance claims.

Before reading any further, we suggest that you review the restrictions and exclusions in your certificate and make sure that you are entitled to benefits.

Furthermore, to be able to study your claim, we must receive the related documents within certain deadlines. These deadlines are indicated in your insurance certificate.

Here is an overview:

Deadlines for submitting claim and supporting documents

- First cancer diagnosis, critical illness, accidental dismemberment, disability: One year after a critical illness or accidental dismemberment is diagnosed or disability begins. If you miss this deadline, you lose your right to receive benefits.
- Life insurance, accidental death: As soon as you are reasonably able.
- Involuntary job loss insurance: Ideally, within 90 days after the event. Otherwise, as soon as you are reasonably able.

Steps in the claim process

Once you have submitted your claim, the following steps will be carried out to assess it and determine the settlement.

Step 1

What you need to send us

At this step, we need your cooperation to gather the information to examine your claim. Once we are informed of the situation:

We

- Will send you forms to be completed by you and those to be filled out by your attending physician or employer, depending on the nature of your claim;
- Will contact your branch, if required, to obtain information about your insured loan or financing product.

You

- Have to make sure that the forms are completed and signed or obtain the required documents;
- Must send us the completed, dated and signed forms or requested documents.

Make sure that you provide us with all information concerning the situation on which your claim is based. This will speed up processing of your request and prevent us from having to contact you or certain people or organizations for further clarification.

When we receive the duly completed forms and documents, we will send you a confirmation of receipt.

Documents to be submitted

In the event of death (including accidental death):

- The life or accidental death insurance claim form, claimant's statement and physician's statement;
- Authorization allowing us to obtain information on the deceased's medical records;
- A copy of the death certificate;
- The accident report, if required and available;
- The coroner's report, if applicable.

You may also be required to provide us with the will or will search certificates.

In case of disability, critical illness, a first diagnosis of cancer or accidental dismemberment:

- The appropriate insurance claim form;
- Authorization allowing us to obtain additional information;
- A declaration from your attending physician;

In the event of loss of employment:

- The loss of employment insurance claim form;
- An employment record completed by your employer;
- A copy of Proof of receipt of benefits;
- Authorization allowing us to obtain additional information.

The documents and forms requested may vary depending on your insurance product.

In all cases, it is important to complete all the forms in full. An incomplete document may result in a delay in studying your claim.

Furthermore, we must receive all the documents required to study your claim with the necessary deadlines, which are indicated in your insurance certificate. If these deadlines are not met, your claim may be rejected.

Step 2

Validation and verification

Once we have received the required forms and documents identified in step 1, we must ensure that we have all the information required. This will allow us to make a decision about your claim and carry out the various checks required by the certificate.

At this point, depending on your situation, our analysts will verify:

- The insurability, based on your medical and personal history;
- The disability, to verify your eligibility based on the hours of remunerated work as required in the certificate;
- The disability, to determine whether you meet the disability and illness definition of the certificate;
- The restrictions and exclusions, as specified in the insurance certificate or policy.

In certain cases, an analyst may contact you to validate certain information.

We may also contact other organizations or individuals to gather information to analyze your claim, including:

- Physicians and specialists;
- Hospitals;
- Your employer;
- Your provincial workers' compensation board or the *Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST)*;
- Your provincial ministry of transportation or the *Société d'assurance automobile du Québec* (SAAQ);
- Your provincial health insurance program or the *Régie de l'assurance maladie du Québec* (RAMQ).

All claims are unique and the process used and time taken to settle your claim will depend on the verification requirements applicable to your case.

We spare no effort to study your claim as quickly as possible.

Step 3

Decision or further examination of your case

After we have completed the checks required in step 2, we contact you, by telephone or mail, with our decision or the subsequent steps that will be taken in assessing your claim.

If your claim involves insurance for a financing product, you are still responsible for making payments while your file is being studied.

Furthermore, we must receive all the documents required to study your claim with the necessary deadlines, which are indicated in your insurance certificate. If these deadlines are not met, your claim may be rejected.

Insurance claim glossary

You will notice that the following terms are frequently used in our correspondence with you. Here are some brief definitions to help you understand the procedure involved.

ATTENTION: The definition of each term may vary from one insurance product to another. These definitions are therefore provided for information purposes only. We recommend consulting the relevant insurance certificate as needed.

Claim

A claim is a request to take advantage of the service offered by your insurance, i.e., benefits payable in the event of death, accidental death, disability, critical illness,loss of employment, a first cancer diagnosis or accidental dismemberment.

To claim is the action of requesting such benefits.

Critical Illness

The critical illnesses covered are: cancer, heart attack and stroke[1].

Disability

A state of incapacity that prevents the insured from performing the normal duties of his occupation.

The disability must be certified by a physician, result from a sickness or an accident suffered while the person was insured and require ongoing medical care.

During the disability, the insured must not engage in any form of work for which he receives compensation in any type.

Pre-existing conditions clause

A pre-existing condition is a state, a disease, a symptom from which you already suffered, for which you consulted a health professional, had medical examinations, took medication or were hospitalized before your insurance came into effect or for which you were being investigated when your insurance came into effect.

Ultimately, this clause concerns restrictions that are related to claims resulting from a pre-existing condition as described above.

Waiting period

The waiting period consists of a specific number of continuous days following an insured event. No benefits are payable during this time.

The length of this period may vary depending on the date you obtained your insurance. Your waiting period is indicated on your certificate.

1 Subjects to the terms and conditions described in the insurance certificate.

Frequently asked questions

To help you understand the claim settlement process, here are some of the questions clients often ask our customer service representatives.

Q Do I have to continue making my payments while my file is being studied?

A Yes, it is always your responsibility to make your payments, even while your claim is being studied or you are receiving benefits.

Q Will you have to write to my doctor?

A If the information provided is considered to be incomplete, particularly with regard to your medical histories, and/or if the supplied information is considered insufficient for us to review your claim, we may be required to contact your physician, hospital, or any other organization involved in order to confirm the information you provided when you applied for your insurance.

Q What can delay the processing of my file?

A Any unanswered questions on your declaration could delay the analysis of your file.

Be sure that all the questions on your declaration and, where applicable, the declaration of your doctor or employer, are answered and that these documents are signed in the space provided and returned to us as quickly as possible.

Q What can I do to speed up processing of my claim?

A If we request additional information from your physician or any other organization, you can contact them and ask them to give your request priority in order to speed up the processing of your claim.

Q To whom will the benefits be paid?

A Once your claim is accepted, the benefits will be paid:

- Loan insurance: to the National Bank, which will then apply the amounts to the repayment of your loan. If you have already made the payment, the benefits will be deposited to your bank account (or the estate account, if applicable);
- Life insurance (individual products): to the beneficiary of the insurance or, if there is no designated beneficiary, to the estate;
- Critical illness insurance: to the insured;
- Credit Card Payment Insurance: to the credit card account.

Q How much will my benefits be?

R The amount we pay out depends on several factors, including the type of insurance, insured amount, balance when the event occurs, etc.

In any case, the amount we pay cannot be higher than maximum payable amount indicated in the certificate.

Millions of dollars paid every year

Every year, we pay millions of dollars to clients who have made the wise decision to subscribe insurance.

The amount paid in benefits affects the amount of the premiums paid by all our insureds. That is why our team of analysts works to ensure that the clauses in each certificate are applied fairly and equitably to all our insureds.

At your service

With insurance from National Bank Life Insurance Company, you can be sure that our entire network understands the difficult situation you are going through, and that every effort will be made to see that you receive the service you deserve.

While your claim is being studied, you may contact the experts from our Customer service department at any time. They will be pleased to keep you informed on the progress of your file and answer any questions you may have.

Do you disagree with a decision made regarding your claim?

Contact us:

By phone
Montreal: 514-394-9904
Toll-free: 1-866-817-4844
By email: assurances@bnc.ca

You can also forward us any document that could justify a revision of our decision.

If the insurer is not able to process your complaint within 14 days, the complaint will automatically be handled by the Client Complaint Appeal Office.

If you received a response within the time specified, but you are still dissatisfied, you can contact the Client Complaint Appeal Office:

Phone: 514-394-8655 or 1-888-300-9004
Website: nbc.ca
Email: complaintappeal@nbc.ca

You can consult the insurer's Complaint Examination Certificate on the website nbc-insurance.ca.

If we haven't addressed your complaint or if you're still dissatisfied and wish to pursue the matter further, you can take any of the following actions:

- Request a revision of your file; or
- Consult your legal advisor; or
- Contact the following organization:

Autorité des marchés financiers (AMF)

Place de la Cité, Cominar Tower
2640, boul. Laurier, 4th Floor,
Québec, QC G1V 5C1

By phone
Québec: 418-525-0337
Montreal: 514-395-0337
Elsewhere in Quebec: 1-877-525-0337
Fax: 1-877-285-4378
Website: lautorite.qc.ca

OmbudService for Life and Health Insurance (OLHI)

Phone, toll-free
Canada: 1-888-295-8112
Toronto: 416-777-9002
Website: olhi.ca

The latest you can submit a legal application against an insurance provider is 3 years following the date the claim was refused.

Should you have any questions, do not hesitate to contact our dedicated claims team.

Montreal: 514-394-9904
Toll free : 1-866-817-4844

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