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

SCOTIA CREDIT CARD PROTECTION
JOB LOSS OR STRIKE / LOCKOUT 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 ELIGIBLITY REQUIREMENT IS 180 DAYS.**

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

Job Loss – Employed Persons: In order to be eligible for these benefits you must be laid off or terminated by your employer. You must have been employed/working for at least 90 consecutive days and working at least 20 hours per week prior to your Job Loss. The Claimant must have become unemployed on or before his or her 70th birthday to claim for Job Loss benefits. For those enrolled in Post-secondary Education and have experienced a Job 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.

Job Loss – Self-Employed Persons: The monthly Job Loss benefit will be paid only if the Claimant is unemployed for 90 consecutive days from a business that has been registered for a minimum of 12 consecutive months. In the case of a self-employed individual with a business that has been registered for a minimum of 12 consecutive months, only one claim will be payable per year per registered business.

Definition of Self-Employed Person: For the purposes of this Job Loss benefit a person is considered to be self-employed or to have had self-employment, if he or she had a registered business and worked for income to be received from a trade or profession in which he or she was engaged, a partnership in which he or she was a partner, his or her own business, or a private company or other entity in which he or she had an ownership interest.

Strike / Lockout:
In order to be eligible for these benefits, you must be employed for at least 90 days immediately prior to the date of Strike or Lockout.

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

In order to review your **Job Loss or Strike/Lockout** claim for eligibility, you must provide **ALL** of the following:

1. **If you are an Employed Person**: Provide the enclosed claim form completed by yourself and your employer, verifying active employment prior to layoff/ termination or strike/lockout.
2. **If you are a Student:** Provide the enclosed claim form completed by yourself and your employer, and the Unemployment Declaration (if not eligible for E.I.C).
3. **If you are Self-Employed** – Provide the enclosed Self-Employed Persons claim form, and the Unemployment Declaration Self-Employed

Please complete one Unemployment Declaration for EACH month of unemployment.

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Job Loss – Employed Persons – Required Documents:

- Copy of your Record(s) of Employment(s) – supporting that you worked a minimum of 90 consecutive days immediately prior to job loss
- Layoff/Termination notice
- Your E.I.C approval letter and proof of receipt of all E.I.C. payments received to date (if applicable)
- If you are not eligible for E.I.C – please complete the Unemployment Declaration

Job Loss – Students – Required Documents:

- Copy of your Record(s) of Employment(s) – supporting that you worked a minimum of 90 consecutive days immediately prior to job loss
- Layoff/Termination notice
- Your E.I.C approval letter and proof of receipt of all E.I.C. payments received to date (if applicable)
- If you are not eligible for E.I.C – please complete the Unemployment Declaration
- Documents Confirming Enrollment in Post-Secondary Education, such as school registration documents

Job Loss – Self-Employed – Required Documents:

- Proof of business registration for a minimum of 12 consecutive months
- Proof of active employment or income for 90 days immediately prior to the date of job loss
- Completion of the enclosed Unemployment Declaration Self-Employed

STRIKE/LOCKOUT– REQUIRED DOCUMENTS:

- Copy of your Record(s) of Employment – supporting that you worked at least 90 consecutive days immediately prior to the date of the Strike or Lockout
- Strike/Lockout notice

To be included: a copy of the following Scotia Credit Card Statements:

- Issued in the month of unemployment or strike/lockout
- For self-employment - Issued in the month your unemployment commenced (prior to the 90 day waiting period)
- The first statement issued immediately after the date of unemployment or strike/lockout

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 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.

UNITY MANAGING UNDERWRITERS LIMITED

Chubb. Insured.℠

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SCOTIA CREDIT CARD PROTECTION CLAIM FORM
JOB LOSS OR STRIKE/LOCKOUT
CLAIMANT STATEMENT & EMPLOYER STATEMENT

Unity Managing Underwriters Ltd.
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CLAIMANT STATEMENT - TO BE COMPLETED BY THE INSURED

Title:	**Name:**	**Scotia Credit Card No.:**
Additional Scotia Credit Card No(s):		**Reference No:**
Address:		
City:	**Province:**	**Postal Code:**
Phone #:	**Email Address:**	
Date of Birth: (MM/DD/YYYY)	**Gender:** ☐ **Male** ☐ **Female** ☐ **Other**	
Name of Last Employer:	**Occupation:**	
Employer Address:		
Date of Hire: (MM/DD/YYYY)	**Last Day Worked:** (MM/DD/YYYY)	
Date Notified of Impending Termination / Layoff: (MM/DD/YYYY)		

Please confirm you have included a copy (scan/photo/screenshot are acceptable) of the following documents in addition to this form in your claim submission package: (see Instruction Sheet for more information)

☐ YOUR LAYOFF/TERMINATION OR STRIKE/LOCKOUT NOTICE
☐ COPY OF RECORD OF EMPLOYMENT
☐ COPY OF CORRESPONDENCE FROM E.I.C. CONFIRMING THE STATUS OF YOUR CLAIM
☐ COPY OF SCOTIA CREDIT CARD STATEMENTS:
- ☐ Issued in the month of layoff/termination or strike/lockout
- ☐ The first statement issued immediately after the date of layoff/termination or strike/lockout

EMPLOYER STATEMENT - TO BE COMPLETED BY THE EMPLOYER

Name of Employee:		
Reason for Unemployment:		
Date of Hire: (MM/DD/YYYY)	**Last Day Worked:** (MM/DD/YYYY)	
Hours Worked / Week:	**Date notified of Impending Termination / Layoff / Strike / Lockout:** (MM/DD/YYYY)	
Company:		
Employer's Name:	**Your Position:**	
Address:		
City:	**Province:**	**Postal Code:**
Telephone Number:	**Fax Number:**	
Email Address:		

I _____ **hereby declare that the above information concerning** _____ **is true to the best of my knowledge.**

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

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 Company of Canada, 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.

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SCOTIA CREDIT CARD PROTECTION CLAIM FORM JOB LOSS SELF EMPLOYED PERSONS CLAIMANT STATEMENT

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E SCCPClaims@umu.net

CLAIMANT STATEMENT - TO BE COMPLETED BY THE INSURED

Title:	**Name:**	**Scotia Credit Card No.:**	
Additional Scotia Credit Cards No(s):			
Address:			
City:		**Province:**	**Postal Code:**
Phone #:		**Email Address:**	
Date of Birth: (MM/DD/YYYY)		**Gender:** ☐ **Male** ☐ **Female** ☐ **Other**	
Name of Business:		**Occupation:**	
Business Registration No:			
Business Address:			
Date of Job Loss, Enforced Business Shut Down or Date of Bankruptcy: (MM/DD/YYYY)			

Please confirm you have included a copy (scan/photo/screenshot are acceptable) of the following documents in addition to this form in your claim submission package:
(see Instruction Sheet for more information)**:**

☐ PROOF OF REGISTRATION OF BUSINESS FOR A MINIMUM OF 12 MONTHS
☐ PROOF OF SELF EMPLOYMENT/INCOME FOR 90 DAYS IMMEDIATELY PRIOR TO DATE OF LOSS
☐ COMPLETION OF UNEMPLOYMENT DECLARATION SELF-EMPLOYED TO SUPPORT UNEMPLOYMENT FOR 90 DAYS AFTER DATE OF LOSS
☐ COPY OF SCOTIA CREDIT CARD STATEMENTS:
- ☐ Issued in the month of unemployment
- ☐ The first statement issued immediately after the date of unemployment (if available)

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 Company of Canada, 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.

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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.

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UNEMPLOYMENT DECLARATION

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I, _____ hereby declare that I am still neither employed nor self-employed and have not received any remuneration of any kind from employment or self-employment for the period of: _____ to _____

I declare that I am actively seeking employment. Listed below are three companies which I have contacted for employment in the last 30 days:

1. Company Name:

Contact Person:

Phone Number:

Date of Contact:

2. Company Name:

Contact Person:

Phone Number:

Date of Contact:

3. Company Name:

Contact Person:

Phone Number:

Date of Contact:

If I obtain employment or self-employment, I will immediately contact Unity Managing Underwriters Ltd. to advise of my return to work.

I agree to repay to Chubb Life Insurance Company of Canada any benefits paid that relate to a period subsequent to the date of my return to employment or self-employment.

Claimant's Signature: _____ Date: _____

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.

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UNEMPLOYMENT DECLARATION
SELF-EMPLOYED

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I, _____ hereby declare that I have been unemployed since _____
[PRINT NAME] [DATE OF JOB LOSS]

and have not received any remuneration of any kind from employment or self-employment since this date.

I declare that I have been actively seeking employment for the month of _____.
[MONTH/YEAR]

If I obtain employment or self-employment, I will immediately contact Unity Managing Underwriters Ltd. to advise of my return to work.

I agree to repay to Chubb Life Insurance Company of Canada any benefits paid that relate to a period subsequent to the date of my return to employment or self-employment.

Claimant's Signature: _____ Date: _____

Claim No.: _____

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