INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

GROUP INSURANCE

CLAIM FORM
Life Insurance

Depending on your region, please submit completed form to:

Quebec
PO Box 790, Station B
Montréal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

CLAIM INSTRUCTIONS

1. If amount of Basic and/or Optional Life Insurance is less than or equal to $75,000, please call 1 877-422-6487
2. Basic Life Insurance – If amount is greater than $75,000, please complete this claim form. However, if amount exceeds $250,000, **also** please ensure that the physician's statement on the reverse side is fully completed and signed by the physician.
3. Optional Life Insurance – If amount is greater than $75,000, please ensure that the physician's statement on the reverse side is fully completed and signed by the physician.

EMPLOYER'S STATEMENT

Policy no. ⌊ ⌋ Division no. ⌊ ⌋ Class no. ⌊ ⌋ Certificate no. ⌊ ⌋

Employer's name _____

Member's name _____ Member's status: ☐ Active ☐ Retired ☐ Disabled

1. The deceased is: ☐ the member ☐ the spouse (Attach marriage certificate, if applicable.) ☐ a dependent child (Attach birth certificate.)

If the deceased is the spouse or a dependent child, go to question 5.

2. Date employed ⌊ Y M D ⌋ Last day worked ⌊ Y M D ⌋ Remained on your payroll to ⌊ Y M D ⌋

3. At the time of death, was the member part of your personnel?

☐ YES Did he/she work until his/her death?

☐ Yes Annual salary at the time of death $ _____

☐ No Reason: ☐ Disability leave, annual salary when disability began $ _____

☐ Other, specify _____

☐ NO Reason for termination of employment: ☐ Retirement, annual salary upon retirement $ _____

☐ Other, specify _____

4. Occupation at the time of death _____ Amount of Life Insurance at time of Death $ _____

5. Employer's signature _____ Date ⌊ Y M D ⌋

Address _____ Tel. ⌊ ⌋

Note: If the member's enrolment forms are in your files, please attach the member's enrolment form if the member is the deceased.

BENEFICIARY'S (CLAIMANT) STATEMENT

1. Beneficiary's name _____ Relationship to insured _____

Address _____ Postal code ⌊ ⌋

Tel. ⌊ ⌋ Date of birth ⌊ Y M D ⌋ Social Insurance Number ⌊ ⌋

- The member is the beneficiary of the life insurance on his/her dependents (spouse and children).
- If the beneficiary designation is legal heirs, administrators, assignees or estate, please attach a copy of the marriage contract and will, if applicable.

2. Name of deceased _____

Date of birth ⌊ Y M D ⌋ Date of death ⌊ Y M D ⌋

3. Cause of death (accidental death: attach the coroner's report. Do not wait for the coroner's report before sending the other documents.)

_____

4. Claimant's name (if different from the beneficiary) _____ Tel. ⌊ ⌋

Address _____ Postal code ⌊ ⌋

5. Did the deceased have a retirement plan or individual contract with Industrial Alliance?

If yes, specify the policy number ⌊ ⌋

Note: Please attach a copy of the official death certificate or have the physician complete and sign the section on the reverse side.
If the face amount is more than $250,000, both documents (the death certificate and the physician's statement) are required.

F54-361A(13-06)

BENEFICIARY (CLAIMANT) CONFIRMATION/AUTHORIZATION

I HEREBY CONFIRM that the information contained in this Claim Form is true and complete to the best of my knowledge.

I HEREBY AUTHORIZE Industrial Alliance to access, copy and review any files in its possession relating to the deceased for the purpose of investigating and processing the deceased's death claim. I also authorize the use of my Social Insurance Number with respect to this claim.

I HEREBY AUTHORIZE any healthcare provider or professional, medical organization, insurance company, reinsurer, the investigation and credit reporting agencies, workers' compensation board, the policyholder, an employer, and any other person and private or public organization or institution to disclose any personal or health information, records or knowledge about the deceased to Industrial Alliance, its employees, its reinsurers or to any agency acting on behalf of Industrial Alliance for the purpose of investigating and processing the insurance claim related to the deceased.

I UNDERSTAND AND AUTHORIZE that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, Industrial Alliance will have the right to use and exchange any information related to the claim with any relevant regulatory, investigative or government body, any healthcare provider or professional medical organization, insurance company or reinsurer, the policyholder, my employer or any other party as provided by law for the purpose of investigating any such fraud or abuse.

I UNDERSTAND that personal information may be subject to disclosure to those authorized under the applicable laws within or outside of Canada.

I AGREE that a photocopy of this Confirmation/Authorization is as valid as the original.

I CONFIRM that I have read the Limitation Period Notice on the reverse side.

Signed at _____ this _____ day of _____ 20 _____

Beneficiary's (claimant) signature _____

Deceased's name: _____ **Date of birth:** ⌊ Y M D ⌋

PHYSICIAN'S STATEMENT

Full name of deceased _____ ☐ Smoker ☐ Non-Smoker

Date of death Y M D _____ Place of death _____ Date of birth Y M D _____

Principal cause of death _____ Date of onset (illness or event) Y M D _____

Causes that contributed to death (if applicable) _____

I attended the deceased from Y M D _____ to Y M D _____

Signed at _____ this _____ day of _____ 20 _____

Physician's name (in block letters) _____

Physician's signature _____

Address _____

LIMITATION PERIOD NOTICE

We are required under certain legislation to advise you that your claim under your group policy is governed by a limitation period that is set out in the Insurance Act or other applicable legislation in your province (e.g. Limitations Act, 2002 (Ontario), Civil Code (Quebec). This means you cannot sue after a certain period of time has passed. You must obtain your own independent advice in regard to this limitation period.