Group Life Insurance Claim Application Guide

**** To avoid unnecessary delays in the processing of this claim, please read these instructions in full.**

For Basic, Supplementary Life and Dependent Life Insurance Claims:

The beneficiary (claimant) should complete the Beneficiary's Statement and submit the completed claim form and the following documents directly to Assumption Life or indirectly through the Policyholder:

- Physician's Statement **(not required for Dependent Life Claims)**
- Provincial Death Certificate or Funeral Director's Statement
- Birth Certificate of the Deceased

Please note that this required supporting documentation list is intended to cover the most common situations. Individual circumstances may require additional information before a claim decision can be made.

Beneficiary (claimant)

1. If the policy is payable to a named beneficiary or beneficiaries:
   a. This statement must be completed by the named beneficiary. If there is more than one named beneficiary, all beneficiaries must sign the statement and provide their addresses. If preferred, separate forms will be supplied upon request.
   b. If any named beneficiary is a minor, this statement must be completed, on behalf of the minor beneficiary, by the guardian or other person authorized by law. A certified copy of the Letters of Guardianship must be submitted (when applicable).
   c. If any named beneficiary is deceased, proof of death must be provided.
   d. If the beneficiary is the estate of the life insured, this statement must be completed by the deceased's executors named in the will, and a notarial copy of the will must be provided. In the province of Quebec, a certified copy of the notarial will is required. If there is no will, this statement must be completed by the administrator of the deceased's estate, and a notarial copy of the Letters of Administration must be provided. In Quebec, this statement must be completed by the heirs of the deceased, and a Declaration regarding Heirs must be submitted.

2. If the policy has no designated beneficiary:
   a. If no beneficiary was designated or if no beneficiary survived the deceased, this statement must be completed by the deceased's estate.
   b. If the deceased left a will, this statement must be completed by the deceased's executors name in the will, and a notarial copy of the will must be provided. In the province of Quebec, a certified copy of the notarial will is required.
   c. If the deceased did not leave a will, this statement must be completed by the administrator of the deceased's estate, and a notarial copy of the Letters of Administration must be provided. In Quebec, this statement must be completed by the heirs of the deceased, and a Declaration regarding Heirs must be submitted.

3. Witness signature on Beneficiary Form:
   a. Individuals who serve as witnesses to legal documents verify that the signature on the document belongs to the person with that name, a witness must be over the age of 18 at the time they witness your signature. Your spouse or another member of your family should not serve as a witness to any legal document you sign. Even if neither party is named in the document, the court holds that your spouse and any relatives still have an interest in your property.

4. Beneficiary's (claimant) Social Insurance Number (SIN):
   a. The Beneficiary's (claimant) SIN is being requested in cases where we would pay $50 or more in interest on the death benefit amount. If the estate of the deceased is the claimant, the deceased's SIN is required.

5. For a Dependent Life claim, the employee of the Province of New Brunswick is the beneficiary.

Beneficiary (claimant) (continued)

Note:

Please return all required documentation to the following address. **Please do not use staples.**

ASSUMPTION LIFE, c/o Group Insurance
P.O. Box 160 / 770 Main Street
Moncton NB E1C 8L1
Telephone: 506-869-9797 or 1-888 869-9797 Fax: 506-853-5434

Alternatively, you can **scan** and **e-mail** the forms to: lifedisability@assumption.ca

Attending Physician (not required for Dependent Life Claims)

1. Please have the deceased's attending physician complete the *Physician's statement.*

2. It is the responsibility of the beneficiary (claimant) to pay any fees that may be incurred to have this form completed by the attending physician of the deceased.

3. The attending physician will return all required information directly to Assumption Life.

Direct Deposit Authorization

Beneficiaries who choose to have the benefits directly deposited into their bank account must complete and attach the Direct Deposit Authorization to the Beneficiary Statement prior to submitting to Assumption Life.

Life Insurance Claim Beneficiary's Statement

________________________ Deceased's First Name
________________________ Deceased's Last Name
954 Policy

**** Attach Employee's Birth Certificate**

Complete a beneficiary section for each beneficiary, if more than one.

Beneficiary's First Name ______ Beneficiary's Last Name ______ Date of Birth (DD/MM/YYYY) ____/____/______

Beneficiary's Address ______ City/Town ______ Province ______ Postal Code ______

Beneficiary's Telephone – Home ______ Beneficiary's Telephone – Work ______ Beneficiary's Telephone – Cell ______

Social Insurance Number ______ Relationship to insured ______ Gender: ☐ F ☐ M

In what capacity are you making this claim? ☐ Beneficiary ☐ Executor ☐ Trustee ☐ Other (specify): ______

Beneficiary's First Name ______ Beneficiary's Last Name ______ Date of Birth (DD/MM/YYYY) ____/____/______

Beneficiary's Address ______ City/Town ______ Province ______ Postal Code ______

Beneficiary's Telephone – Home ______ Beneficiary's Telephone – Work ______ Beneficiary's Telephone – Cell ______

Social Insurance Number ______ Relationship to insured ______ Gender: ☐ F ☐ M

In what capacity are you making this claim? ☐ Beneficiary ☐ Executor ☐ Trustee ☐ Other (specify): ______

Beneficiary's First Name ______ Beneficiary's Last Name ______ Date of Birth (DD/MM/YYYY) ____/____/______

Beneficiary's Address ______ City/Town ______ Province ______ Postal Code ______

Beneficiary's Telephone – Home ______ Beneficiary's Telephone – Work ______ Beneficiary's Telephone – Cell ______

Social Insurance Number ______ Relationship to insured ______ Gender: ☐ F ☐ M

In what capacity are you making this claim? ☐ Beneficiary ☐ Executor ☐ Trustee ☐ Other (specify): ______

Beneficiary's First Name ______ Beneficiary's Last Name ______ Date of Birth (DD/MM/YYYY) ____/____/______

Beneficiary's Address ______ City/Town ______ Province ______ Postal Code ______

Beneficiary's Telephone – Home ______ Beneficiary's Telephone – Work ______ Beneficiary's Telephone – Cell ______

Social Insurance Number ______ Relationship to insured ______ Gender: ☐ F ☐ M

In what capacity are you making this claim? ☐ Beneficiary ☐ Executor ☐ Trustee ☐ Other (specify): ______

Assumption Life
Group Insurance

New Nouveau Brunswick

Beneficiary's Statement Authorization & Acknowledgement

I hereby confirm that the information contained in this claim form is true and complete to the best of my knowledge.

I hereby authorize Assumption Life to access, copy and review any files in its possession relating to the deceased for the purpose of investigating and processing the deceased's life insurance 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, worker's 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 Assumption Life, its employees, its reinsurers or to any agency acting on behalf of Assumption Life for the purpose of investigating and processing the insurance claim related to the deceased.

I understand and acknowledge that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, Assumption Life 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 or 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 agree that a photocopy of this authorization & acknowledgement is as valid as the original.

Signatures are required for each beneficiary, if more than one.

_____ _____
Beneficiary Date (DD/MM/YYYY)

_____ _____
Beneficiary Date (DD/MM/YYYY)

_____ _____
Beneficiary Date (DD/MM/YYYY)

_____ _____
Beneficiary Date (DD/MM/YYYY)

_____ _____
Claimant's signature (if other than a beneficiary) Date (DD/MM/YYYY)

_____ _____
Witness Date (DD/MM/YYYY)

Assumption Life
Group Insurance

New Nouveau Brunswick

Life Insurance Claim Attending Physician's Statement

Instructions:

1. **Please answer each question to avoid file review delays.**
2. **Please attach to the form any other documentation pertinent to the evaluation of this claim (test results of various examinations carried out and specialist consultation reports).**
3. **Please return all required documentation to the following address. Please do not use staples.**

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Telephone: 506-869-9797 or 1-888 869-9797 Fax: 506-853-5434

4. **Alternatively, you can scan and e-mail the forms to: lifedisability@assumption.ca**

_____ _____ 954_____
Deceased's First Name Last Name Policy

1. Date of Death: (DD/MM/YYYY) _____/_____/_____
   Place of residence at death: _____
   If hospital or institution, give name: _____
   Place of death: _____

2. Cause of death:

	Interval between onset and death
Disease or condition directly leading to death (This does not mean the mode of dying such as heart failure, asthenia, etc). It means the primary disease, injury or complication which caused death. _____	
Underlying causes. (Morbid conditions, if any, giving rise to the above cause) a)_____	a)
b) _____	b)
c) _____	c)

3. Other significant conditions (contributing to the death but not related to the disease or conditions causing death) _____

4. Date of **first** attendance for last illness: (DD/MM/YYYY) _____/_____/_____

   Date of **last** attendance for last illness: (DD/MM/YYYY) _____/_____/_____

5. If death was due to accident, suicide or homicide, specify which. _____

Describe briefly: _____

_____

_____

_____

Was an inquest held? ☐ Yes ☐ No

Was an autopsy performed? ☐ Yes ☐ No

If so, by whom and with what findings? _____

_____

_____

_____

6. Have you treated or advised the deceased during the last three (3) years, prior to the last illness? ☐ Yes ☐ No

If yes, please specify:

Nature of Illness or Injury	**Dates** (DD/MM/YYYY)

7. Did the deceased, to your knowledge, receive treatment during the last three (3) years from any other physician, or in any hospital or institution? ☐ Yes ☐ No If yes, please specify:

Nature of Illness or Injury	**Physician, Hospital or Institution**	**Complete Address**	**Date(s) (DD/MM/YYYY)**

Attending Physician's First Name _____ Last Name _____

Full Address _____

Telephone _____ Fax _____

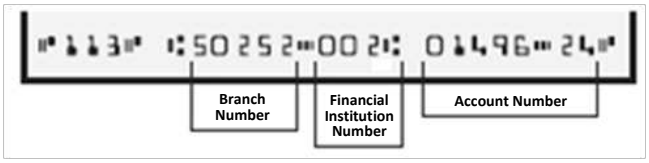
☐ General Practitioner ☐ Specialist (specify) _____ ☐ Other (specify) _____

_____ _____

Signature of Attending Physician Date (DD/MM/YYYY)

NOTE: THE CLAIMANT IS RESPONSIBLE FOR ANY FEES INCURRED TO COMPLETE THIS FORM.

Direct Deposit Authorization

General Information	**Policy:** **954** First Name: _____ Last Name: _____ Address: _____ _____ _____ Telephone: _____
Banking Information	Please attach a blank cheque marked **"VOID"** or provide your banking information below, if no cheque is available. Name of Financial Institution: _____ Address of Financial Institution: _____ _____ _____ Insert the numbers found on the bottom of the cheque, as shown in the following example. Branch Number: ☐☐☐☐☐ Financial Institution Number: ☐☐☐ Account Number: _____ 
Authorization	I hereby authorize and request Assumption Life to credit payments due to me to my account with the financial institution specified above or found on the attached cheque. This authorization may be cancelled at any time upon written notice by me.
Date & Signature	_____ _____ Authorized Signature Date (DD/MM/YYYY)

Attach the completed Direct Deposit Authorization to the Beneficiary Statement and return to:

ASSUMPTION LIFE, c/o Group Insurance
P.O. Box 160 / 770 Main Street
Moncton NB E1C 8L1
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