iA Financial Group

CLAIM FORM
LIFE INSURANCE

GROUP INSURANCE

CLAIM INSTRUCTIONS

1. If the amount of life insurance is less than or equal to $75,000, please call 1-877-422-6487.
2. If the life insurance amount is greater than $75,000, please complete this claim form.
3. If the optional life insurance amount is greater than $75,000 or if the life insurance amount (basic and optional) is greater than $250,000, please ensure that the Physician's Statement on the reverse side is duly 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 directly to point 5 of this section.

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 an employee?

☐ 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 you keep the enrolment forms of your members, please attach the member's enrolment form if he/she is the deceased.

BENEFICIARY'S (CLAIMANT'S) 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.
- If the designated beneficiary is a legal heir, administrator, assignee or the 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 iA Financial Group?

If yes, specify the policy number _____

Note: - Please complete and sign the "Beneficiary (Claimant) Confirmation/Authorization" section on the next page.

- Please attach a copy of the official death certificate or have the physician complete and sign the "Physician's Statement" section on the next page. However, if the life insurance amount is more than $250,000 or the optional life insurance amount exceeds $75,000, both documents (death certificate and Physician's Statement) are required.

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 Insurance and Financial Services inc. (the "Company") 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 or credit reporting agency, workers' compensation board, the policyholder, any 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 the Company, its employees, its reinsurers or to any agency acting on behalf of the Company 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, the Company shall 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 below.

Signed at _____ this _____ day of _____ 20 _____

Beneficiary's (Claimant's) signature _____

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

PHYSICIAN'S STATEMENT (Must be completed if the optional life insurance amount is greater than $75,000 or if the life insurance amount (basic and optional) is greater than $250,000.)

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 treated 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 _____

WHERE TO SUBMIT THIS FORM?

By fax: 1-877-781-1583

By mail: Group Life Claims
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

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.