



**Claims Cover Sheet**

To: **Unity Managing Underwriting**

Claims Email Hotline: [lbipclaims@cashcanada.com](mailto:lbipclaims@cashcanada.com)

Date: \_\_\_\_\_ (dd/mm/yy)

No. of Pages: \_\_\_\_\_ (incl. cover)

Store Number: \_\_\_\_\_

Contact: \_\_\_\_\_

Store Email: \_\_\_\_\_

Store Phone: \_\_\_\_\_

Claimant's Name: \_\_\_\_\_

**Claim Checklist**

**Check boxes for completion:**

Claims Checklist Included ?	<input type="checkbox"/>
Claim Form completed in full ?	<input type="checkbox"/>
Copy of ROE(Record Of Employment) attached?	<input type="checkbox"/>
Copy of loan documents attached ?	<input type="checkbox"/>
Additional Information ? <i>(please note)</i>	<input type="checkbox"/>

**ONCE FAXED, PLEASE ENSURE ALL CLAIM DOCUMENTS ARE STORED IN THE CUSTOMER'S FILE!**

# Involuntary Unemployment

## Notice of Claim

Loan Balance Insurance Protection PRL822



**ACE INA Life Insurance**  
PO Box 1097, Station B,  
Willowdale, ON, M2K 3A2  
Call Toll-free 1-888-561-1101  
Fax to 416-221-1685

<b>LENDER SECTION ONLY</b>		Loan #: _____
Lender's Name: _____	Br #: _____	
Contact Name: _____	Branch _____	
Branch Phone#: _____	Fax #: _____	
Authorization: _____	Branch Signature _____	

### SECTION 1 - CLAIMANT'S STATEMENT (Please print clearly)

- **Only Section 1 is required to be completed if you (the Insured/Claimant) have an ROE (Record Of Employment).**
- If you were unemployed and have not received a Record Of Employment form, have your employer complete and sign Section 2.
- Attach copies of (1) your EI Benefit Statement - Notice of Claim slip ( or correspondence from HRDC confirming the status of your EI claim).
- Mail or fax the completed form and attachments to the Insurer at the address or fax number shown above.

Claimant's Name \_\_\_\_\_  
(Last) (First) (Init)

Address \_\_\_\_\_  
(number, street, apartment number) (city) (province) (postal code)

Telephone No. ( ) Sex  M  F Date of Birth (mm/dd/yyyy) \_\_\_\_\_

Name of Last Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_  
(number, street, apartment number) (city) (province) (postal code)

Date of Hire (mm/dd/yyyy) \_\_\_\_\_ Last Day Worked (mm/dd/yyyy) \_\_\_\_\_ Hours Worked per Week \_\_\_\_\_

Reason For Unemployment \_\_\_\_\_

If you are not eligible for E.I. Benefits, please state reason \_\_\_\_\_

When did you apply for E.I. Benefits? (mm/dd/yyyy) \_\_\_\_\_

**Claimant's Declaration:** The above statements are true and complete to the best of my knowledge and belief.

**PRIVACY NOTICE:** The information provided on this claim form and otherwise in respect of this claim, is required by ACE INA Life Insurance, its reinsurers and authorized administrators (the "Insurer") to assess this claim. For these purposes, the Insurer will also consult its existing insurance files, collect additional information from the claimant and where required, collect information from and exchange information with, third parties. Limited information relating to the status of the claim and the amount of the debt will be exchanged with the creditor who is the beneficiary under this plan, strictly for the purpose of administering insurance benefits. Medical information or details relating to the claimant's employment will not be provided to the creditor without an additional specific authorization to that effect.

**AUTHORIZATION:** I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any employer, physician, practitioner, health care professional, hospital, health care institution, and any other medical or medically related facility, any insurance or reinsurance company, Workers' Compensation Board, HRDC or similar plan or organization, federal, territorial or provincial government department, or any other corporation or organization, institution or association, possessing records or knowledge of me to release and exchange with ACE INA Life Insurance, or representatives thereof, all personal health information, benefit payment, employment or financial information about me or in its possession that is requested while administering this claim. A photocopy of this authorization is as valid as the original.

I understand why I have been asked to disclose this information and the risks and benefits of consenting or refusing to consent. I understand that I can withdraw my consent at any time, but that if I do, the Insurer will not be able to assess my claim and will not pay benefits.

Claimant's Name \_\_\_\_\_ Signature \_\_\_\_\_ Date signed \_\_\_\_\_

### SECTION 2 - EMPLOYER'S STATEMENT (Please print clearly) (only to be completed if No ROE)

Reason For Unemployment: \_\_\_\_\_

If the employee was laid off, when was he/she first advised? (mm/dd/yy) \_\_\_\_\_

Is the employee's normal employment subject to seasonal conditions wherein a lay-off or work suspension is a regular and anticipated part of the work schedule?  Yes  No

**Declaration:** I declare that the information in Section 1 and 2 of this form, concerning the employee and his/her employment, is true to the best of my knowledge.

Signature \_\_\_\_\_ Date Signed (mm/dd/yyyy) \_\_\_\_\_

Print Name \_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_  
(number, street, apartment number) (city) (province) (postal code)



## IMPORTANT!!!

Thank you for completing your application for coverage. Should your claim for benefits be successful you will be eligible for benefit payments equal to the following:

Time Frame	What is Required to Receive Benefit	Benefit Amount
Immediately	Completed claims Package	<b>100%</b> of the outstanding balance on the date you were laid off

**Please bring/fax/email confirmation to your Cash Canada branch for processing.**

### DECLINED

If your claim for benefits is declined, you will be contacted by both your Cash Canada store by phone, and ACE Life Assurance in writing.

You will be required to pay all outstanding payments within three business days of the date the claim was denied, to avoid any late fees. **If payment is not made within the three days grace period your account will be subject to all regular penalties and late fees.**

Should you wish to dispute any decision made by the insurer you may contact your Cash Canada store, or Kent Taylor the Loan Protection Program Manager directly at 1.877.319.7151.