



Claims Cover Sheet

To: **Unity Managing Underwriting**

Claims Email Hotline: 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 ? (Physicians Section Completed)	<input type="checkbox"/>
Copy of Death Certificate 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!

Life Insurance Claim

Payroll Loan Balance Insurance Plan PRL722



SM

ACE INA Life Insurance
P O Box 1097, Station B,
Willowdale, Ontario, M2K 3A2
Toll-free 1-888-561-1101
Fax: 416-221-1685

LENDER SECTION ONLY

Lender Name: _____ Br #. _____

Contact Name: _____

Branch Phone#: _____ Branch Fax#: _____

Authorization: _____

Branch Signature: _____

CLAIMANT'S STATEMENT

THIS SECTION TO BE COMPLETED BY EXECUTOR OR NEXT OF KIN

- To be completed by the Claimant.
- All sections must be fully completed and clearly printed, and attach copies of your Loan Documents.
- The Claimant's Statement and Authorization must be signed by the Claimant.
- Mail or fax both the Claimant's Statement and the Physician's Statement to the Insurer at the address or fax number shown above.

Deceased's Name

_____ (Last) _____ (First) _____ (Init)

Residence at Death

Place of Death

Date of Birth (mm/dd/yyyy)

Place of Birth

Nature of Sickness or Accident

(If accident, state when, where & how)

Date of Death (mm/dd/yyyy)

Onset of Illness (mm/dd/yyyy)

Prior History of Same or Related Illness Yes No (Describe)

Claimant Name

_____ (Last) _____ (First) _____ (Init)

Phone Number ()

Relationship Of Claimant To Deceased Executor Next of Kin Other

Address

_____ (number, street, apartment number) _____ (city) _____ (province) _____ (postal code)

CLAIMANT'S DECLARATION AND AUTHORIZATION

CLAIMANT'S CERTIFICATION: 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 related 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 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 physician, practitioner, health care provider, hospital, health care institution, and any other medical or medically related facility, any insurance or reinsurance company, Workers' Compensation Board or similar plan or organization, federal, territorial or provincial government department, or any other corporation or organization, institution or association, including any group policyholder and employer, possessing records or knowledge of the late _____ (the "Deceased") to release and exchange with ACE INA Life Insurance, or representatives thereof, all personal health information, benefit payment, employment or financial information about the Deceased or any other information or records about the Deceased in its possession that is requested while administering this claim. I am granting this authorization and direction in my capacity as _____ and concerning my interests or rights in such capacity. I agree that a photocopy or facsimile of this authorization shall be 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



SM

Life Insurance Claim - Proof of Death

Payroll Loan Balance Insurance Plan PRL722

ACE INA Life Insurance

P O Box 1097, Station B, Willowdale, Ontario, M2K 3A2

Toll-free 1-888-561-1101

Fax: 416-221-1685

PHYSICIAN'S STATEMENT

THIS SECTION TO BE COMPLETED BY ATTENDING PHYSICIAN

Please complete this form and return it to the Claimant.

The Claimant is responsible for any fee for this information.

The Medical Certification follows the recommendation of the World Health Assembly made in Geneva on July 24, 1948. It has been accepted by all states in the United States and all provinces in Canada. In the interest of accurate vital statistics, please conform to be the international list of causes of death.

Full Name of Deceased

Date of Birth (mm/dd/yyyy)

(Last)

(First)

(Init)

Place of Death (if in hospital or institution, give name)

Date of Death (mm/dd/yyyy)

CAUSE OF DEATH Enter one cause for each of (a), (b), and (c)

Disease or condition directly leading to death:

Interval Between Onset And Death

(This does not mean the mode of dying such as heart failure, asthenia, etc.
It means the disease, injury or complication which caused death).

(a)

(a)

ANTECEDENT CAUSES OF DEATH (Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last)

Due to (b)

(b)

Due to (c)

(c)

Other significant conditions: (Contributing to the death but not related to the disease or condition causing death)

Date of first attendance for last sickness

(mm/dd/yyyy)

Date of last attendance for last sickness:

(mm/dd/yyyy)

Did the deceased receive treatment during the last 3 years from other physician?

Yes

No

If yes, please provide the name and address for each physician consulted.

Signature of Physician

Name

Date

Signed at

Address

(number, street, apt. number)

(city)

(prov.)

(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	100% of the outstanding balance due on the date of Death

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 ACE directly at 1.877.319.7151.