iA Financial Group

Return to:
Life and Health Claims Dept.
400–988 Broadway W, PO Box 5900
Vancouver, BC V6B 5H6

Creditor Life Insurance – Claimants Statement

In furnishing this or other claims forms for the convenience of the claimant the company does not admit any liability or waive any of its rights.

Claimant Must Complete This Area

CERTIFICATE NUMBER(S) OF EACH POLICY UNDER WHICH A CLAIM IS BEING MADE	LOAN NUMBER(S)

SELLING DEALERSHIP	DATE OF PURCHASE D D M M M Y Y Y Y

FINANCE COMPANY/CREDIT UNION NAME	ADDRESS:
CONTACT PERSON AT FINANCE COMPANY	PHONE NUMBER OF FINANCE COMPANY AND LOCAL/EXTENSION

Please Provide The Following Information Regarding The Deceased

FULL NAME OF DECEASED	RESIDENCE ADDRESS
DATE OF DEATH D D M M M Y Y Y Y	CAUSE OF DEATH

PLACE OF DEATH (i.e. home, hospital, work, etc.) & provide name & address	DATE AND PLACE OF BIRTH D D M M M Y Y Y Y	OCCUPATION

Names And Addresses Of All Physicians Who Attended The Deceased In The Past 5 Years

Name	Address	Date	Reason
FAMILY DOCTOR(S) NAME:		D D M M M Y Y Y Y	
OTHER PHYSICIANS:		D D M M M Y Y Y Y	
		D D M M M Y Y Y Y	
		D D M M M Y Y Y Y	
		D D M M M Y Y Y Y	
		D D M M M Y Y Y Y	

Facts Concerning Other Life And Accident Insurance On The Life Of Deceased

Name of Company	Date of Policy	Amount of Insurance
	D D M M M Y Y Y Y	
	D D M M M Y Y Y Y	
	D D M M M Y Y Y Y	

This Section To Be Completed By The Claimant

YOUR NAME (PLEASE PRINT)

YOUR ADDRESS (IN FULL)	POSTAL OR ZIP CODE	PHONE NUMBER

Relationship to Deceased _____

Authorization

As the personal representative of the Insured, I CONSENT to release the information contained in this Claim Form to Industrial Alliance Insurance and Financial Services Inc. (the "Company") and ACKNOWLEDGE that this information will be used to assess, process and administer this claim and policy coverage. I AUTHORIZE any other insurers, reinsurers, and financial institutions; physicians, medical institutions and healthcare providers; employers or administrators of group benefits; agents or brokers; investigating and credit reporting agencies, and all persons or organizations likely to have personal information relevant to the death claim of the life insured, to disclose this information to the Company.

I AUTHORIZE the Company to exchange the information detailed in this Claim Form and other information contained in files related to this claim or coverage with any of the parties identified in the previous paragraph for the purposes listed above, or as authorized by me, or as legally required.

I confirm that a photocopy or electronic copy of this authorization shall be valid as the original.

❑ EXECUTOR ❑ ADMINISTRATOR ❑ OTHER: _____

Signature of claimant	Signature of witness	Date Signed D D M M M Y Y Y Y

**** Please Return With An Original Death Certificate *** ***If you would like the death certificate returned to you check here*** ❑

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Proof of Death – Physician's Statement

Please print in ink

The Claimant is Responsible for any Fee for this Information.

Full Name of Deceased

Policy Number(s)

Residence at Death
Street

City | Province | Postal Code

Occupation

Age at Death or Date of Birth (D D / M M / Y Y Y Y)

Date of Death (D D / M M / Y Y Y Y)

Place of Death

(If Hospital or Institution, Give Name.)

Immediate Cause of Death (That is, the disease, injury or complication which caused death.)

What was the date of onset of the first symptom or sign according to the clinical history? (D D / M M / Y Y Y Y)

How long in your opinion did the disease or impairment exist?

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

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?

Was the Deceased known to be a cigarette smoker?

❑ Yes ❑ No If Yes, furnish information below.

Have you treated or advised the Deceased during the last 5 years, prior to last illness?

❑ Yes ❑ No If Yes, furnish information below.

Did the Deceased, to your knowledge, receive treatment during the last 5 years from any other physician, or in any hospital or institution?

If "Yes", to above questions, please furnish the following

Name of Physician	Address	Nature of Illness or Injury	Date (D D / M M / Y Y Y Y)

Physician's Name (Please Print)

Address
Street | City | Province | Postal Code

Signature MD

Date Signed (D D / M M / Y Y Y Y)