



Assumption Life
Group Insurance

LIFE INSURANCE CLAIM

Life Insurance Claim Instructions

- For a Life Insurance Claim:** The beneficiary (claimant) should complete the *Beneficiary's (claimant'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**)
 - Policyholder's Statement
 - Provincial Death Certificate or Funeral Director's Statement
 - Birth Certificate of the Deceased
- For an Optional Life Insurance Claim:** The beneficiary (claimant) should provide all documentation indicated in section 1 (life insurance claim). If the insurance or increase in insurance is less than two (2) years old, also include an autopsy report and/or medical examiner's report (if applicable).
- For an Accidental Death Claim:** The beneficiary (claimant) should complete the accidental dismemberment forms and include a copy of the police report and coroner's report and/or autopsy report. The documents indicated above in section 1 should also be submitted.

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.

Policyholder (employer or plan administrator)

The policyholder should complete the *Policyholder's Statement* and submit the original group benefit application form and all notice of change requests, if retained.

Beneficiary (Claimant)

- If the policy is payable to a named beneficiary or beneficiaries:**
 - 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.
 - 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).
 - If any named beneficiary is deceased, proof of death must be provided.
 - 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.
- If the policy has no designated beneficiary:**
 - If no beneficiary was designated or if no beneficiary survived the deceased, this statement must be completed by the deceased's estate.
 - 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.
 - 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.
- Beneficiary's (claimant) Social Insurance Number (SIN):**
 - 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.

Beneficiary (Claimant) (continued)

Note:

- a) 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.
- b) 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: 1-855-244-7011 Fax: 1-855-401-9068
- c) Alternatively, you can **scan** and **e-mail** the forms to: lifedisability@assumption.ca

Attending Physician

1. Please complete the *Physician's statement* ensuring that you 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).

Reset

Life Insurance Claim Policyholder's Statement

Employee's First Name _____ Employee's Last Name _____ Policy _____ Division _____ Certificate _____

1. Policyholder's Name: _____

2. Employee's status: Active Retired Disabled Temporary Layoff Other (specify): _____

3. The deceased is: the employee the spouse a dependent child (attach a birth certificate)

If the employee is deceased, please answer questions 4, 5 and 6.

4. Date hired: (DD/MM/YYYY) ____/____/_____
 Last day worked: (DD/MM/YYYY) ____/____/_____
 Remained on payroll to: (DD/MM/YYYY) ____/____/_____

5. At the time of death, was the member part of your personnel?

- 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): _____

6. Occupation at the time of death: _____
 Amount of life insurance in force at the time of death: \$ _____

 First and last name of the authorized person (in block letters)

 Position

 Signature

 Date (DD/MM/YYYY)

Life Insurance Claim Beneficiary's (claimant) Statement

Employee's First Name _____ Employee's Last Name _____ Policy _____ Division _____ Certificate _____

Section 1 Beneficiary's (Claimant's) Information

First Name _____ Last Name _____ Date of Birth (DD/MM/YYYY) ____/____/____

Address _____ City/Town _____ Province _____ Postal Code _____

Telephone - Home _____ Telephone - Cell _____ Email _____

Social Insurance Number _____ Relationship to insured _____ Gender: F M

Claimant's Name (if different from the beneficiary's) _____ Claimant's Telephone _____

Claimant's Complete Address _____

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

Section 2 Deceased's Information

1. Name of deceased: _____
 Date of birth: (DD/MM/YYYY) ____/____/____ Date of death: (DD/MM/YYYY) ____/____/____

2. Complete address where person was residing at time of death: _____

3. Name of personal physician: _____ Since (year): _____
 Did the deceased use any form of tobacco or nicotine? Yes No Unknown

4. Cause of death: _____

5. Was the death accidental? Yes No Unknown

(If death was accidental: Attach coroner's report. Do not wait for the coroner's report to send other documents.)

6. Date the health of the deceased started to decline: (DD/MM/YYYY) ____/____/____

7. Date first treatments related to cause of death were received: (DD/MM/YYYY) ____/____/____

8. Place of death: Home Hospital Nursing Home Other (specify): _____

9. Did death occur in Canada? Yes No If no, name the country: _____

10. Did the deceased consult any physician in the past three (3) years? Yes No Unknown

Was the deceased hospitalized within the past three (3) years? Yes No Unknown

Name and Address of Physician or Hospital	Date/Duration	Reason

11. Did the deceased have a retirement plan or individual policy with Assumption Life? Yes No Unknown

If yes, specify the policy number: _____

Name of employee: _____

Section 3 Beneficiary s (Claimant's) 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.

Claimant's signature

Date (DD/MM/YYYY)

Witness

Date (DD/MM/YYYY)

Life Insurance Claim Physician's Statement

Section 1 To Be Completed by the Beneficiary (Claimant)

First Name	Last Name	Policy	Division	Certificate
___/___/___	_____	_____	_____	_____
Date of birth (DD/MM/YYYY)	Telephone – Home	Telephone - Cell	Telephone - Work	

I hereby authorize any healthcare provider or professional, medical organization, insurance company, reinsurer, the investigation and credit reporting agencies, workers' 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.

Beneficiary's (claimant) Signature	Date (DD/MM/YYYY)
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Section 2 To Be Completed by the Attending Physician

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)

Name of employee: _____

Section 2 To Be Completed by the Attending Physician

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. Was the insured's death related to medical assistance in dying (**M.A.I.D.**)? Yes No

6. 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? _____

7. To the best of your knowledge, was this person using any form of tobacco? Yes No
 When did the deceased start smoking? (DD/MM/YYYY)____/____/_____
 When did the deceased stop smoking (if applicable)? (DD/MM/YYYY)____/____/_____

8. 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)

Name of employee: _____

Section 2 To Be Completed by the Attending Physician

9. 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)

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.



Erase All

Direct Deposit Form

<p>General Information</p>	<p>First name: _____ Last name: _____ Address: _____ _____ Telephone: _____ Policy: _____ Division: _____ Certificate: _____</p>
<p>Banking Information</p>	<p>Please attach a blank cheque marked "VOID", or an official document from your financial institution confirming your account number, branch number and financial institution number.</p>
<p>Authorization</p>	<p>I hereby authorize and request Assumption Life to credit payments due to me to my account with the financial institution indicated on the attached void cheque.</p> <p>This authorization may be cancelled at any time upon written notice by me.</p>
<p>Date & Signature</p>	<p>_____</p> <p>Authorized Signature _____ Date (DD/MM/YYYY)</p>