Assumption Life
Group Insurance

LIFE INSURANCE CLAIM

Assumption Life
Group Insurance

Life Insurance Claim Instructions

1. **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
2. **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).
3. **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)

1. If the policy is payable to a named beneficiary or beneficiaries:

a. 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.
b. 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).
c. If any named beneficiary is deceased, proof of death must be provided.
d. 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.

2. If the policy has no designated beneficiary:

a. If no beneficiary was designated or if no beneficiary survived the deceased, this statement must be completed by the deceased's estate.
b. 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.
c. 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.

3. Beneficiary's (claimant) Social Insurance Number (SIN):

a. 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.

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-855-244-7011 Fax 1-855-401-9068 email : lifedisability@assumption.ca

Assumption Life
Group Insurance

Beneficiary (Claimant) (continued)

Note:

a) It is the responsibility of the beneficiary (claimaint) 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).

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-855-244-7011 Fax 1-855-401-9068 email : lifedisability@assumption.ca

Assumption Life
Group Insurance

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)

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-855-244-7011 Fax 1-855-401-9068 email : lifedisability@assumption.ca

Assumption Life
Group Insurance

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 – Work _____ Telephone - Cell _____

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: _____

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-855-244-7011 Fax 1-855-401-9068 email : lifedisability@assumption.ca

Assumption Life
Group Insurance

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)

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-855-244-7011 Fax 1-855-401-9068 email : lifedisability@assumption.ca

Assumption Life
Group Insurance

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)

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)

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-855-244-7011 Fax 1-855-401-9068 email : lifedisability@assumption.ca

Assumption Life
Group Insurance

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. 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? _____
_____
_____
_____

6. 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) ____/____/_____

7. 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)

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-855-244-7011 Fax 1-855-401-9068 email : lifedisability@assumption.ca

Assumption Life
Group Insurance

Name of employee: _____

Section 2 To Be Completed by the Attending Physician

8. 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)

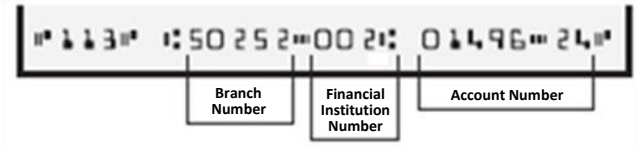
NOTE: THE CLAIMANT IS RESPONSIBLE FOR ANY FEES INCURRED TO COMPLETE THIS FORM.

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-855-244-7011 Fax 1-855-401-9068 email : lifedisability@assumption.ca

Assumption Life
Group Insurance

Reset

Direct Deposit Authorization

General Information	First Name: _____ Last Name: _____ Address: _____ _____ _____ Telephone: _____ Policy: _____ Division: _____ Certificate: _____
Banking Information	Please attach a blank cheque marked **"VOID"** or provide your banking information below, if no cheque is available. Name of Financial Institution: _____ Address of Financial Institution: _____ _____ _____ Insert the numbers found on the bottom of the cheque, as shown in the following example. Branch Number: ☐☐☐☐☐ Financial Institution Number: ☐☐☐ Account Number: _____ 
Authorization	I hereby authorize and request Assumption Life to credit payments due to me to my account with the financial institution specified above or found on the attached cheque. This authorization may be cancelled at any time upon written notice by me.
Date & Signature	_____ _____ Authorized Signature Date (DD/MM/YYYY)

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-888-869-9797 Fax 1-855-401-9068 Email : group@assumption.ca