iA Dealer Services

Life and Health Claims Department
Mailing address: PO Box 5900, Vancouver (BC) V6B 5H6
Street address: 400-988 Broadway West, Vancouver (BC) V5Z 1K7
Toll free: 1 800 549-7227
Fax: 1 833 733-9519 / 604 733-9519

Creditor Claim — Life
Application Kit

The Application Kit contains an instruction sheet plus forms that need to be completed to apply for Life Insurance benefits, and some important information about the claims process itself.

Please keep the instruction sheet for future reference.

The Application Kit includes the following forms, which should be completed and submitted as soon as reasonably possible:

A Creditor Life Insurance – Claimant's Statement

B Proof of Death – Physician's Statement

C Financial Institution – Payout Request

Please also provide a certified true copy of the Death Certificate, a copy of the Will, the Will Search certificates (Quebec), as well as a copy of the Insurance Certificate (iA Creditor Insurance policy).

A Creditor Life Insurance — Claimant's Statement
This form requests information about the certificate, dealership and Financial Institution, the deceased, and the authorized representative of the estate. We need your permission to obtain information that will help us assess your claim. By signing this authorization, you give Industrial Alliance consent to obtain information from the deceased's Physicians, other Healthcare Providers, law enforcement agencies and others, as described in the Authorization.

B Proof of Death — Physician's Statement
This form must be completed by the Physician who attended the deceased at the time of death, his Family Physician or the Coroner. Only a certified true copy of the Coroner's report is sufficient, in lieu of the completed Physician Statement form. This provides us with general information surrounding the deceased's cause of death. You are responsible for any fees the Physician(s) may charge for preparing the forms.

C Financial Institution — Payout Request
This form must be completed by the Finance Company where the loan, covered by this Insurance Certificate, is held. Please have the Finance Company complete this form and return it to our office. The payout must be as of the date of death. Alternatively, a copy of the loan history details from the Finance Company from the onset of the loan to the date of death may also be submitted. Please note that any late payments, charges, interest, missed payments etc. are not covered under this certificate.

Before submitting your claim:

- Please ensure that you have read the Certificate of Insurance carefully, particularly the section entitled "LIMITATIONS AND EXCLUSIONS".
- Please ensure that you have read all the instructions and that all the relevant sections on the Claimant's Statement, Physician's Statement, and Payout Request have been completed in full.
- Please check for completeness as incomplete documentation may cause delays.

To ensure prompt processing of your claim:

- Submit your claim to Industrial Alliance at the address indicated on the claim forms. Please do not fax the forms but send them by mail or courier.
- As our Medical Directors are not familiar with the deceased's medical history, we depend on the quality of medical information given by their Treating Physician(s) to assess the claim.
- We recommend that you submit your claim as soon as possible to avoid unnecessary delays.

Upon receipt of your claim:

- Industrial Alliance Insurance and Financial Services Inc. (Industrial Alliance) evaluates the information included on the application forms to determine your eligibility to claim based on the Certificate of Insurance provisions and the medical evidence provided and obtained.
- We may find it necessary to correspond directly with the deceased's Physician(s) for additional medical information to assess eligibility for benefits.
- Please be advised that we may need to contact you in the future for any additional signed medical authorizations requested by a Physician, Coroner, law enforcement agency or other organization.
- Upon receipt of all original claim forms, we will notify you within 10 business days:
  - If more information is required, or
  - That your claim is approved and paid, or
  - If your claim cannot be processed and the reasons why.

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Creditor Claim — Life
Application Kit (con't)

Important notes and answers to some frequently asked questions:

- You are responsible for any costs associated with providing the initial proof of claim, including the cost of medical information provided by the attending Physician(s) of the deceased. When Industrial Alliance requests information directly from the Physician(s), we will offer to pay a correspondence fee for it.
- A **Doctor of Medicine** must complete the Attending Physician's Statement.
- We remind you that it remains the responsibility of the estate or the co-debtor to continue to make payments to the Financial Institution until the claim is accepted. Therefore, we recommend that you contact the Financial Institution to ensure that you make the necessary arrangements during the assessment of the claim.
- If your claim is accepted, the benefit amount will be the lesser of the following amounts:
  - The outstanding balance of the insured loan on the date of death following a notice from the creditor, less any arrears in payments;
  - In the case of a lease contract, the present value of the outstanding payments and the residual value indicated in the insurance proposal, if applicable;
  - The maximum provided for under the plan.
- Benefit payment is made directly to the Financial Institution, to reduce the financial obligation under the loan. We will notify you of any payments made.
- Please be advised that the Certificate of Insurance does not cover costs related to late or default on payment, or loan extensions.
- You should feel free to call us if you have any questions about your claim or the claims process. One of our Customer Service Representatives will be pleased to answer your questions.
- If you are unable to reach us immediately, please leave a message. We strive to return all calls within one business day.

YOU CAN CONTACT US AT:

Industrial Alliance Insurance and Financial Services Inc.

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A Creditor Claim — Life

Claimant's Statement

Please print in ink.

In providing 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 and/or vin | Date of purchase (yyyy-mm-dd)

Selling dealership

Finance company/credit union name | Address (finance company)

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 | Occupation | Place of birth | Date of birth (yyyy-mm-dd)

Residence address

Date of death (yyyy-mm-dd) | Cause of death | Place of death (i.e. home, hospital, work, etc.) Pls provide name and address

Names and addresses of all physicians and/or clinics who attended the deceased in past 5 years:

Family doctor(s) name | Address | Date (yyyy-mm-dd) | Reason

Other physicians | Address | Date (yyyy-mm-dd) | Reason

Facts concerning other life and accident insurance on the life of deceased:

Name of company | Effective date (yyyy-mm-dd) | Amount of insurance

THIS SECTION TO BE COMPLETED BY THE CLAIMANT

Your name (please print) | Your relationship to deceased

Your address (in full) | Postal Code | Telephone

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.(Industrial Alliance) 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: _____

X _____ X _____ _____

Signature of claimant | Signature of witness | Date (yyyy-mm-dd)

*** Please return with a certified true copy of the Death Certificate, of the Will, of the Will Search certificates (if applicable), and a copy of the Insurance Certificate.**

**** Please retain any copies of the documents you submit for your records as we are unable to return them.**

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B Creditor Claim — Life

Proof of Death — Physician's Statement

Please print in ink.

THE CLAIMANT IS RESPONSIBLE FOR ANY FEE FROM THIS INFORMATION

Full name of deceased

Certificate number(s)

Residence at death, street address

City

Province

Postal Code

Occupation

Date of birth (yyyy-mm-dd)

Date of death (yyyy-mm-dd)

Place of death (i.e. home, hospital, work, etc.)

If hospital or institution, give name

Immediate cause of death (i.e. disease, injury or complication which caused death)

What was the date of onset of the first symptom or sign according to the clinical history? (yyyy-mm-dd)

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? If so, by whom and what were the findings?

☐ Yes ☐ No

Was the deceased known to be a cigarette smoker?

☐ Yes ☐ No

Did the deceased, to your knowledge, receive treatment during the last 5 years from any other Physician, or any hospital or institution? If yes, please provide information below.

☐ Yes ☐ No

Name of Physician, hospital or clinic	Address	Nature of illness or injury	Date (yyyy-mm-dd)

Have you treated or advised the deceased during the last 5 years, prior to last illness? ☐ Yes ☐ No

If yes, please include a complete copy of your patient's medical records, including clinical notes, for the last 12 months to the date of death.

Name of physician/Coroner (please print)

Telephone

Fax

Address

City

Province

Postal Code

X

Signature of Physician/Coroner

Date (yyyy-mm-dd)

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C Creditor Claim — Life

Financial Institution — Payout Request

Please print in ink.

Claimant Name (Please print) | Date of Birth (yyyy-mm-dd) | Certificate Number(s) | Loan Number and/or VIN

TO BE COMPLETED BY THE FINANCE COMPANY WHERE THE LOAN IS HELD

To have all the appropriate loan/lease payout information on hand when our decision is made on the claim, please have Finance Company provide the following information or alternatively a copy of the loan history details from the onset of the loan to the date of death.

☐ Loan ☐ Lease Loan or lease number:

Date of commencement for loan or lease (yyyy-mm-dd) | Date of first payment (yyyy-mm-dd)

Financed amount $ | Interest rate on loan or lease % | Loan or lease term/repayment period | Amortization %

Payment amount $ | Frequency of payments ☐ Monthly ☐ Bi-weekly | Please indicate if loan payments were up to date on the date of **death** ☐ Yes ☐ No

Total loan balance due as of date of **death**, excluding late payments or additional interest charges $

Amount of remaining lease payments as of date of **death**, excluding late payments or additional interest $

CONTACT INFORMATION AT FINANCE COMPANY

Company name

Address | Telephone

Name (Please print) | X Signature | Date (yyyy-mm-dd)

AUTHORIZATION

By signing this document, I authorize Industrial Alliance, Insurance and Financial Services Inc. (the Company) to obtain and exchange personal information regarding the above-named insured, which are required to assess this Creditor Insurance claim. I also authorize the above-named Financial Institution to give any financial information regarding the insured or any required records concerning the Life Insurance claim presented to the Company. This authorization shall remain valid for the duration of the claim review.

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

☐ Executor ☐ Administrator ☐ Other: _____

X Signature of claimant | X Signature of witness | Date (yyyy-mm-dd)