

LIFE INSURANCE CLAIM APPLICATION FORMS

“INSTRUCTIONS”

ALL OF THE FOLLOWING PROPERLY COMPLETED FORMS ARE ESSENTIAL TO THE PROMPT PROCESSING OF YOUR CLAIM:

- INFORMATION RELEASE FORMS (Please complete both Information Release Forms in the event Originals are required)
- CLAIMANT'S STATEMENT
- ATTENDING PHYSICIAN'S STATEMENT
- PROOF OF EXECUTOR (copy of signed Will or Letter of Administration)
- COPY OF DEATH CERTIFICATE AND/OR MEDICAL CERTIFICATE OF DEATH
- COPY OF BIRTH CERTIFICATE OR DRIVER'S LICENSE

Please ensure that all the attached forms are fully completed and that all details listed on the forms are provided by you and the attending physician. (Incomplete forms will be returned for correction which will delay our claim process and our service to you.)

Before you submit your claim for benefits, please read the Certificate of Insurance carefully, in particular the sections entitled “LIMITATIONS AND EXCLUSIONS”.

Under conditions and exclusions of the policy, proof of claim must be submitted to our company on forms supplied by the company within **ninety days** of the event, in order to claim benefits. In no event shall a Proof of Claim be considered valid when submitted more that one year after the event giving rise to the claim.

We remind you that it remains the responsibility of the Estate to continue to make the payments to the Financial Institution (Secured Lender) until the claim is accepted and approved for payment by us. We recommend that you contact the Financial Institution to ensure that they are aware of these circumstances pending claim settlement. All approved claims will be settled under policy limitations as of date of death.

PROMPT REPORTING OF THE CLAIM IS IMPORTANT

UPON RECEIPT OF YOUR COMPLETED CLAIM FORMS WE WILL NOTIFY YOU:

- IF WE NEED MORE INFORMATION
- WHEN YOUR CLAIM IS APPROVED AND PAID
- IF YOUR CLAIM CANNOT BE PROCESSED AND THE REASONS WHY

THE INITIAL EXPENSES REQUIRED FOR PROVIDING THE PROOF OF CLAIM INFORMATION ARE THE RESPONSIBILITY OF THE ESTATE

INFORMATION RELEASE FORM

Before First Canadian Insurance Corporation "FCIC" can determine if this claim is payable, it may be necessary that we obtain additional information on behalf of the Estate, to assist us in determining eligibility.

This may consist of contacting *physician(s), hospital, or other medical health care professionals*, for personal health information (medical history, the *provincial health care organization* for an outline of benefits paid), and pharmacy, for a list of prescribed medications.

In the case of a Motor Vehicle Accident, our office may require details surrounding the accident from the applicable *law enforcement agency* and the *insurance company*.

In all cases, we will need to contact the *financial institution (secured lender)* for loan verification, and updates regarding the status of this account, as all approved benefits are forwarded directly to them to be applied to the loan. FCIC may also advise the *financial institution (secured lender)* of the status of this application.

FCIC, in all cases, will advise you when information is requested on behalf of the Estate. If you require any clarification regarding the necessity of requesting any information on your behalf, please feel free to contact our Claims Department.

You may withdraw your consent at any time, by advising our office, in writing. FCIC, under no circumstances (unless required by law) will release the information received as a result of this release to a third party.

I hereby authorize any physician and other medical health care professionals, provincial health care organization, hospital, financial institution (secured lender), employer, law enforcement agency, insurance company, information bureau, or any organization or person with records or knowledge, of the Insured's health and employment, to release the necessary information to First Canadian Insurance Corporation. A facsimile or photocopy of this authorization shall be as valid as the original.

Name of Deceased Individual That Medical Information Shall Be Released

Signature of Estate Representative

Print Name

Relationship to Deceased

Certificate Number
(See Application for Insurance)

Date

This Consent is Valid for:

- The Term of the Policy
 This Claim only
 Other _____

Witness Signature

Witness Print Name

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Name of Deceased Individual That Medical Information Shall Be Released

Signature of Estate Representative

Print Name

Relationship to Deceased

Certificate Number
(See Application for Insurance)

Date

This Consent is Valid for:

- The Term of the Policy
- This Claim only
- Other _____

Witness Signature

Witness Print Name

CLAIMANT'S STATEMENT

SECTION 1 - INSURED'S PARTICULARS

FULL LEGAL NAME OF DECEASED <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	LAST ADDRESS OF DECEASED	DATE OF BIRTH MONTH DAY YEAR
TELEPHONE (PLEASE INCLUDE AREA CODE) HOME () WORK ()	CITY / PROVINCE POSTAL CODE	CERTIFICATE NUMBER (See Application for Insurance) PROVINCIAL HEALTH CARE NUMBER

SECTION 2 - DETAILS OF YOUR FINANCIAL OBLIGATION

DATE VEHICLE PURCHASED MONTH DAY YEAR	NAME OF DEALERSHIP WHERE VEHICLE PURCHASED																					
VEHICLE DESCRIPTION YEAR MAKE MODEL																						
VEHICLE IDENTIFICATION NUMBER (VIN)	<table border="1" style="width: 100%; height: 20px;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																					
FINANCIAL INSTITUTION (SECURED LENDER)	FINANCIAL INSTITUTION (SECURED LENDER) ADDRESS	PHONE () FAX ()																				
HAS THIS LOAN BEEN RE-WRITTEN OR REVISED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF SO, PLEASE PROVIDE DETAILS	LOAN NUMBER	MONTHLY PAYMENT																				
PLEASE PROVIDE A COPY OF THE FINANCE / LEASE CONTRACT. (IF THERE ARE ANY ADDENDUMS AND/OR REVISIONS, PLEASE INCLUDE THIS DOCUMENTATION.)																						
IS THERE MORE THAN ONE ACTIVE LOAN / LEASE INSURED THROUGH FIRST CANADIAN INSURANCE CORPORATION? IF SO, YOU WILL NEED TO SUPPLY ALL INFORMATION IN SECTION 2 FOR THE OTHER FINANCIAL OBLIGATION(S)		<input type="checkbox"/> YES <input type="checkbox"/> NO																				

SECTION 3 - CLAIMANT'S PARTICULARS

NAME OF PERSON SIGNING THIS FORM (PLEASE PRINT)	ADDRESS	RELATIONSHIP TO INSURED <input type="checkbox"/> SPOUSE <input type="checkbox"/> SON / DAUGHTER <input type="checkbox"/> EXECUTOR / EXECUTRIX <input type="checkbox"/> LEGAL COUNSEL <input type="checkbox"/> OTHER (SPECIFY BELOW)
TELEPHONE (PLEASE INCLUDE AREA CODE)	CITY / PROVINCE	
POSTAL CODE	EMAIL: DO YOU CONSENT TO CORRESPONDING VIA EMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO	
PLEASE PROVIDE A COPY OF DOCUMENTATION FROM THE ESTATE CONCERNING YOUR AUTHORITY TO MAKE APPLICATION IN THIS MATTER SUCH AS PROOF OF EXECUTOR		

IS THE CLAIM THE RESULT OF A MOTOR VEHICLE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
WAS THE VEHICLE INSURED UNDER THIS POLICY INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO

Continued on next page

ATTENDING PHYSICIAN'S STATEMENT

FULL LEGAL NAME OF DECEASED (Please Print)					
DATE OF BIRTH		HOW LONG DID YOU ATTEND THIS PATIENT?		DATE OF DEATH	
YEAR / MONTH / DAY	YEAR / MONTH / DAY	YEAR / MONTH / DAY	YEAR / MONTH / DAY	YEAR / MONTH / DAY	YEAR / MONTH / DAY
CAUSE OF DEATH: PRIMARY					

DUE TO OR AS A CONSEQUENCE OF					

WERE DRUGS / ALCOHOL A FACTOR?		YES / NO	IF YES, PLEASE EXPLAIN.		
IS DEATH DUE TO ACCIDENT		YES / NO	IS DEATH DUE TO SUICIDE		YES / NO
BRIEFLY DESCRIBE CIRCUMSTANCES SURROUNDING DEATH					
PLEASE PROVIDE A PHOTOCOPY OF THE MEDICAL CERTIFICATE OF DEATH. (IF AVAILABLE)					
PLEASE PROVIDE DATE OF FIRST CONSULTATION (BY ANY MEDICAL HEALTH CARE PROFESSIONAL) FOR THE PHYSICAL CONDITION AND / OR ANY SYMPTOMS WHICH RESULTED IN THE INSURED'S DEATH.				YEAR	MONTH / DAY
PLEASE SUPPLY ALL DATES ATTENDED AND DETAILS REGARDING THE DATE OF DIAGNOSIS; AND ALL DOCUMENTATION TO SUPPORT DIAGNOSIS					
PLEASE LIST ALL OTHER HEALTH CARE PROFESSIONALS INVOLVED. IF THERE ARE ANY REPORTS AVAILABLE FROM THESE SOURCES, PLEASE INCLUDE THESE IN YOUR RESPONSE.					

THIS INFORMATION IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE OF PHYSICIAN	PRINTED NAME AND ADDRESS OF PHYSICIAN
DATE (YEAR / MONTH / DAY)	

ANY CHARGES FOR THE COMPLETION OF THIS FORM OR PROVISION OF RELATED DOCUMENTS ARE THE RESPONSIBILITY OF THE CERTIFICATE HOLDER'S REPRESENTATIVE