

INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

**GROUP INSURANCE** 

			CLAIM FORM
Depending on your reg <b>Quebec</b> PO Box 790, Station B Montréal, Quebec H3f		rinces	Life Insurance
CLAIM INSTRU	CTIONS		
<ol> <li>Basic Life Insu please ensure</li> <li>Optional Life In</li> </ol>	urance – If amount is greater than \$7 that the physician's statement on the	s less than or equal to \$75,000, please call 1 877 '5,000, please complete this claim form. However e reverse side is fully completed and signed by th \$75,000, please ensure that the physician's state	r, if amount exceeds \$250,000, <b>also</b> he physician.
EMPLOYER'S S	TATEMENT		
-	Division no.	Class no.	
Member's name		Member's status:	Active Retired Disabled
	is: the member the spouse ( <i>i</i> is the spouse or a dependent child	Attach marriage certificate, if applicable.) a dependent of the dependence of the de	ndent child (Attach birth certificate.)
2. Date employed	y M D d ∟ Last day	y worked	n your payroll to
□ YES	Other, specify	of death \$ ye, annual salary when disability began \$ y	
∐ NO	Reason for termination of employme	ent:  Retirement, annual salary upon retiremer Other, specify	
4. Occupation at	the time of death	Amount of Life Insurance	
5. Employer's sig	jnature		Date M D
Address			Tel.
Note: If the memb	per's enrolment forms are in your files	s, please attach the member's enrolment form if	the member is the deceased.
BENEFICIARY'S	S (CLAIMANT) STATEMENT		
1. Beneficiary's n	name	Relationship to insured	
Address			Postal code
Tel.	Date of birth	Y M D Social Insurance Num	ber 💷 💷 👘 👘 👘
	siary designation is legal heirs, admin	ce on his/her dependents (spouse and children). histrators, assignees or estate, please attach a co	opy of the marriage contract and will,
Date of birth	Date of dea	ath	
3. Cause of deat	h (accidental death: attach the coroner's i	report. Do not wait for the coroner's report before send	ding the other documents.)
4. Claimant's nar			Tel
	sed have a retirement plan or individu	ual contract with Industrial Alliance?	
If yes, specify	the policy number		
		cate or have the physician complete and sign the nents (the death certificate and the physician's st	
	CLAIMANT) CONFIRMATION/AUTH		
I HEREBY AUTHORIZE II I also authorize the use I HEREBY AUTHORIZE a the policyholder, an em Industrial Alliance, its er I UNDERSTAND AND AL any information related the policyholder, my em I UNDERSTAND that per	of my Social Insurance Number with respect to the any healthcare provider or professional, medical or ployer, and any other person and private or public mployees, its reinsurers or to any agency acting on JTHORIZE that in the event there is reasonable sus to the claim with any relevant regulatory, investiga aployer or any other party as provided by law for the	files in its possession relating to the deceased for the purpose of in- nis claim. rganization, insurance company, reinsurer, the investigation and cr c organization or institution to disclose any personal or health info n behalf of Industrial Alliance for the purpose of investigating and p spicion of or any evidence of fraud or abuse regarding the claim, Ino ative or government body, any healthcare provider or professional the purpose of investigating any such fraud or abuse. o those authorized under the applicable laws within or outside of C	redit reporting agencies, workers' compensation board, ormation, records or knowledge about the deceased to processing the insurance claim related to the deceased. dustrial Alliance will have the right to use and exchange medical organization, insurance company or reinsurer,

I CONFIRM that I have read the Limitation Period Notice on the reverse side.

Signed at	this	_ day of			20	
Beneficiary's (claimant) signature				Y	М	D
Deceased's name:			Date of birth:			

PHYSICIAN'S STATEMENT				
Full name of deceased	Smoker 🗌 Non-Smoker			
Date of death	death	Date of birth		
Principal cause of death		Date of onset у м D		
Causes that contributed to death (if applicable)		(illness or event)		
I attended the deceased from	•			
Signed at	this day of	20		
Physician's name (in block letters)				
Physician's signature				
Address				

## LIMITATION PERIOD NOTICE

We are required under certain legislation to advise you that your claim under your group policy is governed by a limitation period that is set out in the Insurance Act or other applicable legislation in your province (e.g. Limitations Act, 2002 (Ontario), Civil Code (Quebec). This means you cannot sue after a certain period of time has passed. You must obtain your own independent advice in regard to this limitation period.