



# Creditor Life Insurance – Claimants Statement

In furnishing 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(S)	
SELLING DEALERSHIP		DATE OF PURCHASE D   D   M   M   M   Y   Y   Y   Y	
FINANCE COMPANY/CREDIT UNION NAME	ADDRESS:		
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	RESIDENCE ADDRESS		
DATE OF DEATH D   D   M   M   M   Y   Y   Y   Y	CAUSE OF DEATH		
PLACE OF DEATH (i.e. home, hospital, work, etc.) & provide name & address	DATE AND PLACE OF BIRTH D   D   M   M   M   Y   Y   Y   Y	OCCUPATION	

### Names And Addresses Of All Physicians Who Attended The Deceased In The Past 5 Years

Name	Address	Date	Reason
FAMILY DOCTOR(S) NAME:		D   D   M   M   M   Y   Y   Y   Y	
OTHER PHYSICIANS:		D   D   M   M   M   Y   Y   Y   Y	
		D   D   M   M   M   Y   Y   Y   Y	
		D   D   M   M   M   Y   Y   Y   Y	
		D   D   M   M   M   Y   Y   Y   Y	
		D   D   M   M   M   Y   Y   Y   Y	

### Facts Concerning Other Life And Accident Insurance On The Life Of Deceased

Name of Company	Date of Policy	Amount of Insurance
	D   D   M   M   M   Y   Y   Y   Y	
	D   D   M   M   M   Y   Y   Y   Y	
	D   D   M   M   M   Y   Y   Y   Y	

### This Section To Be Completed By The Claimant

YOUR NAME (PLEASE PRINT) \_\_\_\_\_

YOUR ADDRESS (IN FULL) \_\_\_\_\_ POSTAL OR ZIP CODE \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

Relationship to Deceased \_\_\_\_\_

### Authorization

As the personal representative of the Insured, I CONSENT to release the information contained in this Claim Form to Industrial Alliance Pacific Insurance and Financial Services Inc. ("IAP") 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 IAP.

I AUTHORIZE IAP 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: \_\_\_\_\_

Signature of claimant \_\_\_\_\_ Signature of witness \_\_\_\_\_ Date Signed \_\_\_\_\_  
D | D | M | M | M | Y | Y | Y | Y

\* Please Return With An Original Death Certificate \* If you would like the death certificate returned to you check here