Claim for Life Benefits - Creditor Insurance
Bank Statement

Canadian Premier Life Insurance Company - A Securian Financial company
Claims Department
25 Sheppard Ave. W, Suite 1400, Toronto, ON M2N 6S6
1-877-736-4753 • Fax 1-866-748-8486 • creditor.claims@canadianpremier.ca

Policy 83028

Instructions:
- This form to be completed by Embark Student Corp.
- Once the claim forms are complete, please return to Canadian Premier Life Insurance Company, Group Life Claims, 25 Sheppard Ave. W, Suite 1400, Toronto, ON M2N 6S6

Canadian Premier Life Insurance Company, a Securian Financial Company, is committed to keeping your information confidential.

Deceased Information

Legal name of insured (first, middle, last)

Last mailing address (street, city, province, postal code)

Date of birth (dd/mm/yyyy)	Date of death (dd/mm/yyyy)

Savings Information

Identification	Frequency	Insurance effective date (dd/mm/yyyy)

Date of first claimed deposit (dd/mm/yyyy)	Date of last claimed deposit (dd/mm/yyyy)

Amount claimed	Claimed deposits	Amount per deposit
$		$

I certify that all the above statements are full, complete and true to the best of my knowledge.

Authorized representative (print name)	Title	Telephone number

Signature of authorized representative	Date signed (dd/mm/yyyy)
X	

By furnishing this form or any other form, the Company does not admit that any coverage is in force nor waive any of its rights or defenses.

Claim for Life Benefits - Creditor Insurance
Statement of Authorized Representative

Canadian Premier Life Insurance Company - A Securian Financial company
Claims Department
25 Sheppard Ave. W, Suite 1400, Toronto, ON M2N 6S6
1-877-271-8713 • Fax 1-866-748-8486 • creditor.claims@canadianpremier.ca

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There are four (4) forms that are required to begin the claim process:

- Statement of Authorized Representative - To be completed by the deceased's estate representative.
- Physician Statement
- Funeral Directors certificate of death OR the official death certificate.
- Bank statement - completed by the authorized representative.

Deceased's Information

Legal name of insured (first, middle, last)	Date of birth (dd/mm/yyyy)	Date of death (dd/mm/yyyy)

Address (street, city, province, postal code)

Date the deceased first complained or gave other indication of his/her last illness (dd/mm/yyyy)	Date the deceased first consulted a physician for his/her last illness (dd/mm/yyyy)
Immediate cause of death	**Country of death**

Place of death

☐ Hospital ☐ Long term care facility ☐ Residence ☐ Other

If death occurred as a result of an accident, please provide details

Please provide the name and address of the deceased's family physician:

Legal name of physician (first, middle, last)

Address (street, city, province, postal code)

Please provide the names and addresses of all physicians and all hospitals where the deceased received treatment during the 5 years prior to death:

Legal name (first, middle, last)	Address (street, city, province, postal code)
Disease or condition	Date treated
Legal name (first, middle, last)	Address (street, city, province, postal code)
Disease or condition	Date treated
Hospital	Address (street, city, province, postal code)
Disease or condition	Date treated

Your permission

I certify that the information is true and correct. I authorize Canadian Premier, the plan administrator(s), and their agents and service providers to collect, use and disclose information needed for underwriting, administration and adjudicating claims under this insurance policy relating to ______________________________ (the life insured) with any person or organization who has relevant information pertaining to this claim including health professionals, government agencies, provincial health care plans, institutions, investigative agencies, insurers and reinsurers. I understand that information pertaining to this claim may be reviewed in the event that this plan is audited. I agree that a photocopy of this authorization or electronic version is as valid as the original and shall remain in effect for the duration of the claim adjudication.

Name of deceased's authorized representative	Relationship to deceased (e.g., next of kin, executor/executrix, etc.)

Address (street, city, province, postal code)

See Reverse Side

If you would like Canadian Premier to write you through secure email, please provide your email address below.

Signature of authorized representative **X**	Telephone number	Date (dd/mm/yyyy)

Email address

How to submit your completed form(s)

You have multiple ways of submitting your completed claim forms to us, along with any other information in support of your claim. For all options, except for mail, you can keep the original copies for your records.

You can send in your completed claim forms directly to Canadian Premier by email *creditor.claims@canadianpremier.ca*. Please be advised that although Canadian Premier uses reasonable means to protect the security and confidentiality of the email content it sends and receives, the privacy or security of email communications cannot be guaranteed.

You can fax your completed claim forms to the number that appears below. If you are unable to fax this information, you can mail it to the appropriate address.

Fax: 1-866-748-8486

Canadian Premier Life Insurance Company
25 Sheppard Ave. West, Suite 1400
Toronto, ON M2N 6S6

For questions about your claim, you may call Canadian Premier.

Phone: 1-877-271-8713

Important notes

- For deaths that occur outside North America, additional documentation may be required. Canadian Premier Life Insurance Company will contact you.
- Canadian Premier Life Insurance Company will inform you if your claim is subject to further investigations.
- Deadline to submit a claim:
  - For all provinces and territories outside of Quebec, as soon as possible, but within one year of the date of death.
  - For Quebec residents, as soon as possible but within three years of the date of death.
- Any required proof relating to a claim is at the expense of the representative submitting the claim.
- Retain a copy of the claim package for your records.

Respecting your privacy

Respecting your privacy is a priority for Canadian Premier Life Insurance Company. We collect information from application forms and other information you provide to us or our distribution partners in connection with insurance and/or financial products offered by us, as well as (with your consent) through independent medical or vocational assessments, if applicable, and from physicians, medical practitioners, hospitals, clinics or other medical or medically related facilities, insurance companies, MIB, LLC (“MIB”), and other agents, government agencies or other organizations, institutions, or persons that have health records, if applicable. We collect, use and disclose your personal information for purposes that include: confirming your identity, underwriting, including determining your eligibility or need for insurance and/or financial products you request; administration and servicing; claims adjudication; protecting against fraud, errors or misrepresentations; and meeting legal, regulatory or contractual requirements. We will give access to your personal information only to those of our employees and independent contractors, affiliates within our corporate group, administrators, distribution partners, and other third-party service providers and outsourcers, along with our reinsurers, who need your personal information to do their jobs. We will also provide access to anyone else you authorize. All of our service providers with whom we have a contractual relationship are required to protect your personal information in accordance with this privacy statement and our privacy practices. Sometimes, unless we are otherwise prohibited, these people may be in, or your personal information may be stored on servers located in, other provinces in Canada or in countries outside Canada, so your personal information may be subject to the laws of those other provinces or countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit http://www.canadianpremier.ca/privacy-statement.

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Claim for Life Benefits - Creditor Insurance
Attending Physician Statement

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Instructions:

- Please return this form to the authorized representative once it is completed.
- Any cost incurred for the completion of this form is the authorized representative's responsibility.

Deceased Information

Deceased legal name (first, middle, last)	Date of birth (dd/mm/yyyy)

Date of death (dd/mm/yyyy)	Date the deceased first consulted you for the condition causing death (dd/mm/yyyy)

Immediate cause of death	Date of diagnosis (dd/mm/yyyy)
Contributory cause of death	Date of diagnosis (dd/mm/yyyy)

Death was due to
☐ Natural causes ☐ Suicide ☐ Accident ☐ Homicide Please provide details:

Were alcohol or drugs a contributing factor to the death?
☐ Yes ☐ No If yes, please provide details:

Have you treated or advised the deceased during the last 5 years?
☐ Yes ☐ No If yes, please provide details:

Disease or condition	Dates treated
Disease or condition	Dates treated
Disease or condition	Dates treated
Disease or condition	Dates treated
Disease or condition	Dates treated
Disease or condition	Dates treated
Disease or condition	Dates treated

See Reverse Side

Did the deceased, to your knowledge, receive treatment during the last 5 years from any other physician, health practitioner, or in any hospital or institution?

☐ Yes ☐ No If yes, please provide the following: (attach extra sheets, if necessary)

Legal name (first, middle, last)	Address
Disease or condition	Dates treated
Legal name (first, middle, last)	Address
Disease or condition	Dates treated
Legal name (first, middle, last)	Address
Disease or condition	Dates treated
Legal name (first, middle, last)	Address
Disease or condition	Dates treated
Hospital	Address
Disease or condition	Dates treated
Hospital	Address
Disease or condition	Dates treated
Hospital	Address
Disease or condition	Dates treated

Physician's signature

I certify that the information in this form is true and correct.

Physician legal name (first, middle, last)		
Specialty	Telephone number	Fax number
Address (street, city, province, postal code)		
Physician's signature **X**		**Date signed (dd/mm/yyyy)**

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