Assumption Life

Life Insurance Claim – Beneficiary's (Claimant) Statement

First Name of the deceased _____ Last Name of the deceased _____ Policy Number _____

Section 1 – Beneficiary's (Claimant's) Information

In what capacity are you making this claim?
☐ Beneficiary ☐ Executor/Liquidator ☐ Trustee ☐ Assignee ☐ Other (specify): _____

The Social Insurance Number or Business Number is required for reporting of interest and/or other tax reporting requirements.
If you are a beneficiary making this claim, please provide your Social Insurance Number (SIN)_____
If you are a representative of an estate making this claim, please provide the deceased insured's SIN_____
If you are a representative of a corporate beneficiary, please provide the Business Number used for tax purposes_____
If you are a trustee making this claim on behalf of a beneficiary, please provide the beneficiary's SIN_____
Your business is located in Quebec, please also provide the Quebec Business Number_____

Did the deceased leave a Will ☐ Yes ☐ No ☐ Unknown

First Name of the beneficiary _____ Last Name of the beneficiary _____ Date of Birth (DD/MM/YYYY) _____

Address of the beneficiary _____ City/Town _____ Province _____ Postal Code _____

Telephone - Home _____ Telephone – Work _____ Telephone – Cell Phone _____

Relationship to insured _____ Gender: ☐ F ☐ M

Claimant's Name (if different from the beneficiary's) _____ Claimant's Telephone _____

Claimant's Complete Address _____ Claimant's e-mail address _____

Section 2 – Deceased's Information

1. Name of deceased : _____
   Date of birth : (DD/MM/YYYY) _____ Date of death : (DD/MM/YYYY) _____
2. Complete address where person was residing at time of death : _____
   _____
3. Name and address of personal physician(s) or family doctor(s) consulted by the insured in the last 5 years preceding death :
   Name :_____City :_____From which date : _____
   Name :_____City :_____From which date : _____
   Did the deceased use any form of tobacco or product containing nicotine? ☐ Yes ☐ No ☐ Unknown
   If yes, specify dates :_____
4. Cause of death: _____
5. Was the death accidental? ☐ Yes ☐ No ☐ Unknown
   (If death was accidental, attach coroner's report. Do not wait for the coroner's report to send other documents.)
6. Date the health of the deceased started to decline : (DD/MM/YYYY) _____
7. Date first treatments related to cause of death were received : (DD/MM/YYYY) _____

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-800-455-7337 Fax 1-855-230-2500 email: claims@assumption.ca

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8. Place of death : ☐ Home ☐ Hospital ☐ Nursing Home ☐ Other (specify): _____

9. Did death occur in Canada? ☐ Yes ☐ No
If the death occurred outside of Canada or the U.S.A., Form 4765-00A Foreign Death Questionnaire must also be completed.

10. Did the deceased consult any physician in the past three (3) years? ☐ Yes ☐ No ☐ Unknown
Was the deceased hospitalized within the past three (3) years? ☐ Yes ☐ No ☐ Unknown

Name and Address of Physician or Hospital	Date/Duration	Reason

Section 3 – Beneficiary's (Claimant's) Authorization & Acknowledgement

Choose one of the following options (if no choice is made, the cheque will be sent to the advisor):
☐ Direct Deposit (see attached form named *Direct Deposit Authorization*) ☐ Mail cheque to address indicated in Section 1
☐ Send cheque to the Assumption Life advisor ☐ Invested in Assumption Life's diversified products*
***A financial advisor will contact you shortly to guide you towards the solution that will best meet your needs.**

Declaration of tax residence for the beneficiary (claimant)
Please indicate all of the options that apply to you in respect to Section 1 of this form.
☐ **I am a tax resident of Canada.** If you ticked this box, give your social insurance number. Social insurance number _____
☐ **I am a tax resident or a citizen of the United States**.
If you ticked this box, give your taxpayer identification number (TIN) from the United States. TIN from the United States _____
If you do not have a TIN from the United States, have you applied for one? ☐ Yes ☐ No
☐ **I am a tax resident of a jurisdiction other than Canada or the United States**.
If you ticked this box, give your jurisdictions of tax residence and taxpayer identification numbers. _____
If you do not have a TIN for a specific jurisdiction, give the reason using one of these choices:
Reason 1 : I will apply or have applied for a TIN but have not yet received it.
Reason 2 : My jurisdiction of tax residence does not issue TINs to its residents.
Reason 3 : Other reason.
For this form, "other reason" is enough. However, you still have to tell your financial institution the specific reason.

Jurisdiction of tax residence	Taxpayer identification number	If you do not have a TIN, choose reason 1, 2, or 3.

***For Assignee**, you will be required to complete a *Declaration of Tax Residence for Entities- Part XVIII and Part XIX of the Income Tax Act*.
This form will be provided to you upon reception of this claim.

I hereby confirm that the information contained in this claim form is true and complete to the best of my knowledge.

I hereby authorize Assumption Life to access, copy and review any files in its possession relating to the deceased for the purpose of investigating and processing the deceased's life insurance claim. I also authorize the use of the social insurance number with respect to this claim.

I hereby authorize any healthcare provider or professional, medical organization, insurance company, reinsurer, the investigation and credit reporting agencies, worker's compensation board, and any other person and private or public organization or institution to disclose any personal or health information, records or knowledge about the deceased to Assumption Life, its employees, its reinsurers or to any agency acting on behalf of Assumption Life for the purpose of investigating and processing the insurance claim related to the deceased.

I understand and acknowledge that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, Assumption Life will have the right to use and exchange any information related to the claim with any relevant regulatory, investigative or government body, any healthcare provider or professional or medical organization, insurance company or reinsurer, the policyholder, my employer or any other party as provided by law for the purpose of investigating any such fraud or abuse. I agree that a photocopy of this authorization & acknowledgement is as valid as the original.

_____ _____
Beneficiary's signature (Claimant) Date (DD/MM/YYYY)

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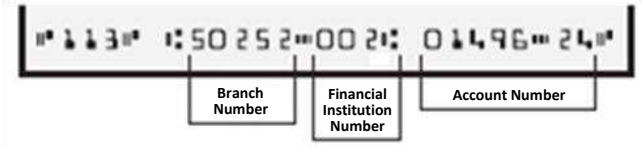
Direct Deposit Authorization

General Information	First Name: _____ Last Name: _____ Address: _____ _____ _____ Telephone: _____ Policy: _____
Banking Information	Please attach a blank cheque marked **"VOID"** or provide your banking information below, if no cheque is available. Name of Financial Institution: _____ Address of Financial Institution: _____ _____ _____ Insert the numbers found on the bottom of the cheque, as shown in the following example. Branch Number: ☐☐☐☐☐ Financial Institution Number: ☐☐☐ Account Number: _____ 
Authorization	I hereby authorize and request Assumption Life to credit payments due to me to my account with the financial institution specified above or found on the attached cheque. This authorization may be cancelled at any time upon written notice by me.
Date & Signature	_____ _____ Authorized Signature Date (DD/MM/YYYY)

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Instructions for completing the claimant's statement

If the policy is payable to a named beneficiary or beneficiaries

a. This statement must be completed by the named beneficiary. If there is more than one named beneficiary, all beneficiaries must sign the statement and provide their addresses. If preferred, separate forms will be supplied upon request.
b. If any named beneficiary is a minor, this statement must be completed, on behalf of the minor beneficiary, by the guardian or other person authorized by law. A certified copy of the Letters of Guardianship must be submitted (when applicable).
c. If any named beneficiary is deceased, proof of death must be provided.
d. If the beneficiary is the estate of the life insured, this statement must be completed by the deceased's executors named in the will, and a notarial copy of the will must be provided. In the province of Quebec, a certified copy of the notarial will is required. If there is no will, this statement must be completed by the administrator of the deceased's estate, and a notarial copy of the Letters of Administration must be provided. In Quebec, this statement must be completed by the heirs of the deceased, and a Declaration regarding Heirs must be submitted.

If the policy has no designated beneficiary and the owner of the policy is the deceased

If no beneficiary survived the deceased, this statement must be completed by the deceased's estate.

a. If the deceased left a will, this statement must be completed by the deceased's executors named in the will, and a notarial copy of the will must be provided. In the province of Quebec, a certified copy of the notarial will is required.
b. If the deceased did not leave a will, this statement must be completed by the administrator of the deceased's estate, and a notarial copy of the Letters of Administration must be provided. In Quebec, this statement must be completed by the heirs of the deceased, and a Declaration regarding Heirs must be submitted.

If the policy has no beneficiary and the owner of the policy differs from the deceased

a. If no beneficiary survived the deceased, this statement must be completed by the owner of the policy, if living. If the owner is also deceased and left a will, this statement must be completed by the owner's executors named in the will, and a notarial copy of the will must be provided. In the province of Quebec, a certified copy of the notarial will is required.
b. If no beneficiary survived the deceased and the owner of the policy is deceased and left no will, this statement must be completed by the administrator of the owner's estate, and a notarial copy of the Letters of Administration must be provided. In Quebec, this statement must be completed by the heirs of the deceased, and a Declaration regarding Heirs must be submitted.

If the policy is assigned

This statement must be completed by the assignee and the beneficiary. Payment will be made jointly to the beneficiary and the assignee.

Claimant's Social Insurance Number (SIN)

The claimant's SIN is being requested in cases where we would pay $50 or more of interest on the death benefit amount. If the estate of the deceased is the claimant, the deceased's SIN is required. If the estate of the owner is the claimant, the owner's SIN is required. If you do not wish to provide your SIN, we will contact you in the event that it's absolutely necessary.

If you are a US person in regards to US tax purposes and the benefits payable are greater than $50,000.00 (fifty thousand dollars), your US Taxpayer Identification Number (TIN) is required in accordance with the US Foreign Account Tax Compliance Act (FACTA).

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