First Canadian Insurance Corporation

320 SIOUX ROAD
SHERWOOD PARK, ALBERTA
CANADA T8A 3X6
TEL: (780) 467-9575
FAX: (780) 467-4650

LIFE INSURANCE CLAIM APPLICATION FORMS

"INSTRUCTIONS"

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

- INFORMATION RELEASE FORM
- CLAIMANT'S STATEMENT
- ATTENDING PHYSICIAN'S STATEMENT
- PROOF OF EXECUTOR (copy of signed Will or Letter of Administration if available)
- 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 of the policy, proof of claim must be submitted to our company on forms supplied by the company within **one year** 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 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

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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 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 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, 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. I authorize the Lender to release a copy of my Finance Contract, Statement of Account as well as loan verification and updates as required. 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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CLAIMANT'S STATEMENT

SECTION 1 - INSURED'S PARTICULARS

FULL LEGAL NAME OF DECEASED	LAST ADDRESS OF DECEASED	DATE OF BIRTH MONTH DAY YEAR
TELEPHONE *(PLEASE INCLUDE AREA CODE)* HOME ( ) WORK ( )	CITY / PROVINCE	CERTIFICATE NUMBER (See Application for Insurance)
	POSTAL CODE	PROVINCIAL HEALTH CARE NUMBER

SECTION 2 - DETAILS OF YOUR FINANCIAL OBLIGATION

LOAN DATE MONTH DAY YEAR	AGENT/AGENCY	
LENDER	LENDER ADDRESS	PHONE ( ) FAX ( )
HAS THIS LOAN BEEN RE-WRITTEN OR REVISED? ❑ YES ❑ NO IF SO, PLEASE PROVIDE DETAILS	LOAN NUMBER	MONTHLY PAYMENT
PLEASE PROVIDE A COPY OF THE FINANCE CONTRACT. (IF THERE ARE ANY ADDENDUMS AND/OR REVISIONS, PLEASE INCLUDE THIS DOCUMENTATION.)		
IS THERE MORE THAN ONE ACTIVE LOAN INSURED THROUGH FIRST CANADIAN INSURANCE CORPORATION? IF SO, YOU WILL NEED TO SUPPLY ALL INFORMATION IN SECTION 2 FOR THE OTHER FINANCIAL OBLIGATION(S)	❑ YES ❑ NO	

SECTION 3 - CLAIMANT'S PARTICULARS

NAME OF PERSON SIGNING THIS FORM (PLEASE PRINT)	ADDRESS	RELATIONSHIP TO INSURED ❑ SPOUSE ❑ CHILD ❑ EXECUTOR / EXECUTRIX ❑ LEGAL COUNSEL ❑ OTHER (SPECIFY BELOW)
TELEPHONE *(PLEASE INCLUDE AREA CODE)*	CITY / PROVINCE	
POSTAL CODE	EMAIL: DO YOU CONSENT TO CORRESPONDING VIA EMAIL? ❑ YES ❑ 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? ❑ YES ❑ NO

Continued on next page

WAS THE INSURED HOSPITALIZED? ❑ YES ❑ NO	IF "YES", NAME OF HOSPITAL ***PLEASE PROVIDE A COPY OF THE EMERGENCY ROOM REPORT AND THE DISCHARGE SUMMARY***	DATES HOSPITALIZED FROM TO
NAME OF DOCTOR TREATING THIS ILLNESS	DOCTOR'S ADDRESS CITY PROVINCE POSTAL CODE	DOCTOR'S TELEPHONE PHONE ( ) FAX ( )
NAME OF FAMILY DOCTOR OF INSURED WHEN DID THE INSURED BECOME PART OF THIS DOCTOR'S PRACTICE?	DOCTOR'S ADDRESS CITY PROVINCE POSTAL CODE	DOCTOR'S TELEPHONE PHONE ( ) FAX ( )
NAME OF FAMILY DOCTOR ON EFFECTIVE DATE OF COVERAGE WHEN DID THE INSURED BECOME PART OF THIS DOCTOR'S PRACTICE?	DOCTOR'S ADDRESS CITY PROVINCE POSTAL CODE	DOCTOR'S TELEPHONE PHONE ( ) FAX ( )
PLEASE LIST THE PHARMACY(IES) WHERE THE INSURED HAD HIS/HER MEDICATIONS FILLED	PHONE NUMBER(S)	MEDICATIONS FILLED
1.		
2.		
3.		
4.		

PLEASE PROVIDE A LIST OF ALL OTHER INSURANCE COMPANIES FOR WHICH THE INSURED HAS INSURANCE COVERAGE, INCLUDING ADDRESS, TELEPHONE NUMBER AND CONTACT INFORMATION.

PLEASE PROVIDE OUR OFFICE WITH ANY ADDITIONAL INFORMATION YOU FEEL WILL ASSIST IN THE ADJUDICATION OF THIS CLAIM.

STATEMENT OF CERTIFICATION

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HEREBY REQUEST FIRST CANADIAN INSURANCE CORPORATION TO ADJUDICATE THIS CLAIM IN ACCORDANCE WITH THE TERMS, CONDITIONS, AND LIMITATIONS OF THE GROUP POLICY UNDER WHICH THE DECEASED WAS A CERTIFICATE HOLDER. I UNDERSTAND THAT ALL PHONE CONVERSATIONS WITH FCIC REPRESENTATIVES ARE RECORDED FOR QUALITY ASSURANCE, TRAINING PURPOSES AND DISPUTE RESOLUTION.

SIGNED AT CITY PROV	DATE YEAR MONTH DAY
SIGNATURE OF INSURED'S REPRESENTATIVE OR CLAIMANT	PRINT NAME CLEARLY HERE
SIGNATURE OF WITNESS	PRINT NAME CLEARLY HERE

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

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ATTENDING PHYSICIAN'S STATEMENT

FULL LEGAL NAME OF DECEASED (Please Print)		
DATE OF BIRTH YEAR / MONTH / DAY	HOW LONG DID YOU ATTEND THIS PATIENT? YEAR / MONTH / DAY	DATE OF DEATH 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	WAS AUTOPSY PERFORMED IF SO, PLEASE PROVIDE COPY	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