CLEAR FORM

simplii FINANCIAL

Mortgage Life Insurance Claim

When should a Mortgage Life Insurance claim be made?

- If the deceased has Life Insurance under Creditor Insurance for Simplii Financial™ Mortgages

What do I need to submit with the Mortgage Life claim?

☐ Original or notarized copy of proof of death

☐ For accidental death, attach coroner's report, autopsy report, and police accident report if available

☐ The following sections of this claim form, fully completed and signed:

- **Deceased's Authorized Representative Statement**
- **Family Physician Statement**

Where do I submit the Claim?

Once all sections are complete, mail or fax the document(s) to:

Mail: Simplii Financial™, National Servicing Centre, Commerce Court Postal Station, P.O. Box 115, Toronto, ON M5L 1E5
Fax: 1-866-452-4795

Note: Any missing information may cause your claim to be delayed

What happens after a Claim is submitted?

- The Mortgage Loan will remain open and payments must continue to be made by the joint account holder or the Estate Representative;
- You will be advised if further information is required to process your claim;
- Upon approval of your claim, the Insurer will make your benefit payments to Simplii Financial™. A notice will be sent to you indicating the payment made;
- if your claim is denied the Insurer will advise you in writing.

Where to find more information

- Refer to your Certificate of Insurance for information about the terms, conditions, limitations, exclusions and other provisions of your coverage,,
- **Call the Creditor Insurance Helpline at 1 800 465-6020.**
- You may also contact Canada Life at 1 800 387-4495 or visit www.canadalife.com

Your Privacy Matters - a note from the Insurers

- Creditor Insurance for Simplii Financial™ Mortgages is underwritten by The Canada Life Assurance Company (Canada Life).
- When the deceased insured client requested coverage for his/her Simplii Financial mortgage loan, he/she gave the insurer information about himself/herself, which the insurer added to a client file. The purpose of this file is to allow the insurer and their reinsurers to conduct all the necessary business of insurance, including setting premiums, receiving payments, assessing and paying claims, and keeping insured clients informed of the status of the coverage. The insurer keeps client files at their head office or another secure location.
- Only authorized personnel have access to information about the insured client. The insured client's Authorized Representative may also arrange to have access to or correct the insured client's personal information, by calling the Creditor Insurance Helpline at **1-800-465-6020**.

DECEASED'S AUTHORIZED REPRESENTATIVE STATEMENT

Information about the Mortgage Loan

You can submit the same form for up to 5 Simplii mortgage loans.

Mortgage Loan Number	Mortgage Loan Number	Mortgage Loan Number	Mortgage Loan Number	Mortgage Loan Number

Information about the Deceased

Name of Deceased - First Name | Initial | Last Name

Date of Birth (Month day, year) | Gender ◯ Male ◯ Female

Mailing Address (Number and Street)

City | Province | Postal Code

Information about the Authorized Representative

Details of other life insurance of deceased
(Company and Policy numbers)

Name of Deceased's
Authorized Representative | Relationship to the
Deceased

Mailing Address (Number and Street)

City | Province | Postal Code

Telephone
Number | Cell Number
(optional) | Email address
(optional)

Name of Deceased's Family Physician in
the 24 months prior to the Date of Death

Address of Deceased's
Family Physician | Telephone
Number

I authorize any doctor, health practitioner, hospital, clinic, other medical or medically related facility, the Medical Information Bureau (MIB), insurance company, employer, consumer reporting agency, government board or agency, law enforcement agency or other organization, institution or person that has any record or information regarding the above named deceased (including any record or information regarding psychologically related and HIV/AIDS related conditions) to release any such records or information to Canada Life, Simplii insurance administrators, and reinsurers. Canada Life may contact me using the contact information I have provided above, for the purposes of administering this claim.

A photographic copy of this authorization shall be valid as the original.

Date (Month day, year) | Name and Title of Authorized Representative (please print) | X Signature of Authorized Representative

FAMILY PHYSICIAN STATEMENT

Note: Any charge for completing this form is the claimant's responsibility

Name of Deceased - First Name | Initial | Surname

Date of Birth (Month day, year) | Place of Death | Date of Death (Month day, year)

Immediate Cause | Contributory Cause(s)

Date of First Treatment for conditions causing death WITHIN the 12 month period prior to the date of death (Month day, year)

Was the patient seen in the 12 months prior to date of death? ◯ Yes ◯ No | If yes, provide date of visit (Month Day, Year)

Date of diagnosis of condition causing death (Month Day, Year) | Date of Last Treatment (Month Day, Year)

Manner of death (please tick appropriate box) ◯ Accident ◯ Suicide ◯ Natural Causes | Provide additional details

Was an inquest held? ◯ Yes ◯ No | If yes, by whom and what were the findings (attach findings)

Was an autopsy performed? ◯ Yes ◯ No | Deceased has been your patient since (Month Day, Year)

Give details of any conditions for which you treated the deceased during the 12 months prior to death whether or not related to the cause of death.

Date	Diagnosis	Treatment Prescribed	Type of Surgery, if any

Name and Address of any other doctors who, to your knowledge, may have treated the deceased prior to death (attach note if insufficient space)

Name	Address

Mortgage Life Insurance Claim

Name of Family Physician (please print)

Name of Facility (Hospital, Medical Center)

Telephone Number

Mailing Address (Number and Street)

City

Province

Postal Code

Fax Number

These statements are true and complete to the best of my knowledge.

Date (Month day, year)

Name and Title of Family Physician (please print)

X

Signature of Family Physician (sign within box)