IWS Creditor Group

Western LIFE ASSURANCE

Life Claims Package

IMPORTANT!

We are pleased to provide you with this claims package. There are some important points we would like to bring to your attention, to ensure that your claim is processed as fast as possible:

1. **Please ensure that every field is fully completed by the executor or next of kin, and the deceased's Physician.**

2. **Please ensure that you enter your email address in "Section 1: Claimants Section". We email most claim communication, and want to be sure that you are always up to date with the status of your claim.**

3. **On the last page of this claims package the 'What Happens Now' section. Please read this section so you know exactly what to expect with the claim, and specifically the last section that requires your signature acknowledging you must return this claims package within five business days.**

Before sending in the claims package please ensure that you thoroughly go over the 'Claims Checklist' on page 2 of this claims package to ensure you have everything complete and supporting documents attached. While emailing is preferred, you can submit your completed claims package using any of the three methods below:

Email: cashmoney@iwsinc.ca
Claims Fax Hotline: 1.888.341.4888
Mail: **IWS Creditor Group/Western Life Assurance**
300- 495 Richmond St.,
London ON N6A 5A9

Cash Money is not the insurer and plays no part in determining coverage or in claims adjudication or disposition.

Death Benefit – Claim Package

Administration Office

IWS Creditor Group/Western Life Assurance
300- 495 Richmond St.,
London ON N6A 5A9

Claims Info Hotline: **1-866-210-1296**
Claims Fax Hotline: **1-888-341-4888**
Claims Email : cashmoney@iwsinc.ca
(For claims submission only)

Claim Information

Date: _____ (dd/mm/yy) No. of Pages:_____ (incl. cover)

Claimants Name: _____

Phone: _____

Claim Checklist

Please note that ALL claims info must be received in order to process claim
(Please check boxes when completed)

Claim Form completed in full ? ***(Doctor's/Employer's section completed)***	
Copy of Death Certificate	
Copy of loan documents outstanding on date of death?	
Additional Information? *(please note)*	

IMPORTANT

1. the administration office must be notified within **30 days** of the date of Death
2. the completed claim form (*see checklist below*) must be submitted to the administration office within **90 days** of the date of insureds death

Submitted By:	Please Note
Claimant	• Please ensure ALL documents are either emailed to cashmoney@iwsinc.ca ; faxed to number above or mailed to IWS Creditor Group. • Please watch for confirmation from IWS that the claim was received (If you are sending pictures of completed docs to email in, please ensure photo is clear)

Life Insurance Claim Form

Loan Protection Program # CM01004

Western Life Assurance Company
C/O IWS Creditor Group
495 Richmond St., Suite 300, London, ON, N6A 5A9
(F) 1-888-341-4888 (E) cashmoney@iwsinc.ca

CLAIMANT'S STATEMENT
This section to be completed by Executor or Next of Kin

- **To be completed by the claimant**
- **All sections must be fully completed and clearly printed, and attach copies of your loan documents.**
- **The Claimant's Statement and Authorization must be signed by the Claimant.**
- **Mail, fax or email both the Claimant's Statement and the Physician's Statement to the Insurer at the address or fax number shown above.**

Deceased's Name

_____
(Last) (First) (Int)

Claimant Email: _____

(In order to process your claim as efficiently as possible, most written communication is sent via email. Please ensure you check all mailboxes for emails from the domains @iwsinc.ca (eg. cashmoney@iwsinc.ca)

Residence at Death _____ Place of Death _____

Date of Birth (mm/dd/yyyy) _____ Place of Birth _____

Nature of Sickness
(if accident, state when, where & how) _____

Date of Death (mm/dd/yyyy) _____ Onset of Illness (mm/dd/yyyy) _____

Prior History of Same or Related Illness __ No __ Yes (describe) _____

Claimant Name _____ Phone Number ( ) _____
(Last) (First) (Int)

Relationship of Claimant to Deceased ___ Executor ___ Next of Kin ___ Other _____

Address

_____
(number, street, apartment number) (city) (province) (postal code)

CLAIMANT'S DECLARATION AND AUTHORIZATION

CLAIMANT'S CERTIFICATION: **The above statements are true and complete to the best of my knowledge and belief.**

PRIVACY NOTICE: **The information provided on this claim form and otherwise in respect of this claim, is required by Western Life Assurance Company, it's reinsurers and authorized administrators (the "Insurer") to assess this claim. For these purposes, the Insurer will also consult its existing insurance files, collect additional information from the claimant and where required, collect information from and exchange information with, third parties. Limited information related to the status of the claim and the amount of the debt will be exchanged with the creditor who is the beneficiary under this plan, strictly for the purpose of administering insurance benefits. Medical information will not be provided to the creditor without an additional specific authorization to that effect.**

AUTHORIZATION: **I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, and any other medical or medically related facility, any insurance or reinsurance company, Worker's Compensation Board or similar plan or organization, federal, territorial or provincial government department, or any other corporation or organization, institution or association, including any group policyholder and employer, possessing records or knowledge of the late _____ (the "Deceased") to release and exchange with Western Life Assurance Company, or representatives thereof, all personal health information, benefit payment, employment or financial information about the Deceased or any other information or records about the Deceased in its possession that is requested while administering this claim. I am granting this authorization and direction in my capacity as _____ and concerning my interests or rights in such capacity. I agree that a photocopy or facsimile of this authorization shall be as valid as the original. I have provided my personal email address above for the purpose of receiving communication regarding this claim. I give Western Life Assurance Company and its representative's permission to communicate the details about this claim using the email address provided.**

I understand why I have been asked to disclose this information and the risks and benefits of consenting or refusing to consent. I understand that I can withdraw my consent at any time, but that if I do, the Insurer will not be able to assess my claim and will not pay benefits.

_____ _____ _____
Claimant's Name Signature Date (dd/mm/yyyy

Life Insurance Claim – Proof of Death

Loan Protection Program #CM01004

Western Life Assurance Company
C/O IWS Creditor Group
495 Richmond St., Suite 300, London, ON, N6A 5A9
(F) 1-888-341-4888 (E) cashmoney@iwsinc.ca

PHYSICIAN'S STATEMENT

This section to be completed by Attending Physician

Please complete this form and return it to the Claimant.
The Claimant is responsible for any fee for this information.

The Medical Certification follows the recommendation of the World Health Assembly made in Geneva on July 24, 1948. It has been accepted by all states in the United States and all provinces in Canada. In the interest of accurate vital statistics, please conform to the international list of causes of death.

Full Name of Deceased _____ Date of Birth _____
(Last) (First) (Init) (mm/dd/yyyy)

Place of Death _____ Date of Death _____
(if in hospital or institution, give name) (mm/dd/yyyy)

CAUSE OF DEATH Enter one cause for each of (a), (b) and (c)

Disease of condition directly leasing to death: Interval Between Onset and Death

(This does not mean the mode of dying such as heart failure, asthenia, etc.
It means the disease, injury or complication which caused death).

(a)_____ (a)_____

ANTECEDENT CAUSES OF DEATH (Morbid Conditions, if any, giving rise to the above cause (a) stating the underlying cause last)

Due to (b)_____ (b)_____

Due to (c)_____ (c)_____

Other significant conditions: (Contributing to the death but not related to the disease or condition causing death)

_____

Date of first attendance for last sickness _____
(mm/dd/yyyy)

Date of last attendance for last sickness _____
(mm/dd/yyyy)

Did the deceased receive treatment during the last 3 years from another physician? ☐ Yes ☐ No

If yes, please provide the name and address for each physician consulted. _____

Signature of Physician | Name | Date | Signed at

Address _____
(number, street, unit number) (city) (prov.) (postal code)

Death Benefit
Claims Payment Disclosure

What Happens Now?

Claim is Sent to IWS

- If claims are sent directly to IWS, IWS will provide confirmation of receipt of this claim to both Cash Money and yourself.

Claim is Processed by IWS

- Once ALL required documents are received, claims processing takes 48-72 hours
- If any documents or supporting material is missing we will notify you and CashMoney by email

Claim is Approved by IWS

- **Once a file has been approved**
  - A benefit equal to the principal outstanding balance on the date of death will be paid to CashMoney to be applied to the unpaid account

Claim is Declined by IWS

- If your claim for benefits is declined, you will be contacted by both CashMoney by phone and Western Life/IWS in writing.
- Should you wish to dispute any decision made by the insurer you may contact IWS directly at 1.855.377.7542.

IMPORTANT

While you, as the executor or next-of-kin to the deceased are not responsible for, and are not required to make loan payments while the claim is being adjudicated and until any benefit payments are received by Cash Money, please be aware that fees and interest continue to accrue, as permitted by applicable law. **Claim benefits do NOT include any late penalty of arrears interest.**

Furthermore, completed documents should be received within the five (5) business days, to ensure that your claim can be processed as soon as possible and no unnecessary interest and late fees are accrued.

Claimant Signature: _____