Canadian Premier
LIFE INSURANCE COMPANY

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 is 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 four methods below:

1. **Email:** claims@premiumservicesgroup.ca
2. **Claims Fax:** 1.888.341.4888
3. **Mail:** Premium Services Group
   300- 495 Richmond St.,
   London ON N6A 5A9
4. **Upload by Lender:** If you choose, you may request that the Lender upload the claims documents directly to Premium Services Group on your behalf by completing the Consent Form below.

CONSENT FORM

To: _____ [Name of lender] (**the** "Lender")

I hereby confirm that I have requested that the Lender scan and submit certain claims and other related forms (the "Forms**") to Premium Services Group Inc. ("**PSG**") on my behalf. I consent to the collection, use and disclosure of my personal information contained in the Forms by the Lender for the purpose of uploading and transmitting such Forms to PSG, provided that the Lender shall either return to me or securely destroy the Forms following such transmission and shall not retain any personal information contained in the Forms.**

Dated _____
Month / Day / Year

_____
Claimant Signature

_____
Claimant Name (please print)

Lend Direct Corp. is not the insurer and plays no part in determining coverage or in claims adjudication or disposition.

Canadian Premier
LIFE INSURANCE COMPANY

Death Benefit – Claim Forms

Administration Office

Premium Services Group
300- 495 Richmond St.,
London ON N6A 5A9

Claims Info: **1-866-766-4566 ext. 4056**
Claims Fax: **1-888-341-4888**
Claims Email: **claims@premiumservicesgroup.ca**

Claim Information

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

Claimant's Name: _____

Phone: _____ ext._____ E-mail: _____

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?	
Copy of Death Certificate?	
Copy of line of credit 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 the insured's death

Submitted By:	Please Note
Customer	• Please ensure ALL documents are faxed/emailed to the contact info above • Please watch for email confirmation from PSG that file was received (If you are sending pictures of completed docs to email in, please ensure photo is clear)

Life Insurance Claim Form

Line of Credit Protection Program #LOC001-LD01

Canadian Premier Life Insurance Company
C/O Premium Services Group Inc.
495 Richmond St., Suite 300, London, ON, N6A 5A9
FAX 1-888-341-4888

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 Line of Credit documents.**
- **The Claimant's Statement and Authorization must be signed by the Claimant.**
- **Mail or fax 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 **@premiumservicesgroup.ca** (eg. **claims@premiumservicesgroup.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 Canadian Premier Life Insurance Company, its 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 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 Canadian Premier Life Insurance 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 Canadian Premier Life Insurance 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

Line of Credit Protection Program #LOC001-LD01

Canadian Premier Life Insurance Company
C/O Premium Services Group Inc.
495 Richmond St., Suite 300, London, ON, N6A 5A9
FAX 1-888-341-4888

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)

LENDDIRECT

Death Benefit
Claims Payment Disclosure

What Happens Now?

Claim is Sent to PSG

- Claims are to be sent directly to PSG

Claim is Processed by PSG

- 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 Lend Direct by email

Claim is Approved by PSG

- Once a file has been approved
  - A benefit equal to the outstanding balance (up to the maximum indicated in the Certificate of Insurance) on the date of death will be paid to Lend Direct to be applied to the unpaid account

Claim is Declined by PSG

- If this claim for benefits is declined, you will be contacted by PSG in writing.
- Should you wish to dispute any decision made by the insurer you may contact PSG.

IMPORTANT

Please note that loan payments are required to be kept up to date while this claim is being adjudicated and until the payment is received by Lend Direct, in order to avoid additional interest and fees from accumulating. **Claim Benefits do NOT include any late penalty or arrears interest.**

Furthermore, if the completed documents are not received within the five (5) business days, we will assume that you have decided not to proceed with your claim and all late fees and interest will be accrued back to the date your last payment was due.

Claimant Signature: _____