Foresters Financial

789 Don Mills Road
Toronto, ON M3C 1T9
Canada

foresters.com

Foresters Life Insurance Company (FLIC) claims: Tel: 800 828 1540 Fax: 877 329 4631

Canada Protection Plan, A Foresters Financial Company claims: Tel: 877 629 9090 Fax: 877 329 4631

Statement of Claim for Death Benefits

On behalf of Foresters Financial™, please accept our condolences for your loss. We understand that this is a difficult time for you and your family. Please know that we will make every effort to process your claim promptly. We strive to provide service of the highest standards and take pride in assisting you in your claim for benefits.

To ensure timely handling of your claim, it is important that your submission contain all necessary information requested in the Claimant's Statement.

Please review the following checklist prior to submitting your claim:

- ☐ Complete all sections of the Claimant's Statement and sign where required. If there is more than one claimant, please ensure that a separate Claimant's Statement is completed by each claimant. Copies can be made of this document.
- ☐ If claimant's name has changed please provide legal documentation supporting the change.
- ☐ Obtain a certified copy of the decedent's Provincial Death Certificate or original Funeral Director's Statement of Death. **Note:** Only one Certified Provincial Death Certificate or Funeral Director's Statement of Death is required per decedent with multiple certificates and/or claimants. Include the original document, if available. Death Certificates and Funeral Director's Statements of Death become a part of the claim file and will not be returned.
- ☐ If the last known beneficiary has died, please provide us with a copy of the beneficiary's Provincial Death Certificate or Funeral Director's Statement of Death.
- ☐ If the claim form is to be completed by an Executor, Administrator or a Legal Guardian, a copy of the filed document supporting that appointment must be submitted with the Claimant's Statement.
- ☐ If the claim form is to be completed by a Trustee, please be sure to include the Trust Account Number or the Social Insurance Number of the Trustee. Additionally, please provide a copy of that portion of the trust referring to the successor trustee(s) along with a statement that the trust is currently in effect.
- ☐ If any portion of the death benefit will be assigned, please include the funeral assignment and a copy of the funeral bill.
- ☐ **Complete only if the death occurred outside the United States or Canada.** Please submit the official death certificate issued in the country where the death occurred and provide a notarized translation of the death certificate. We also require the enclosed Foreign Death Questionnaire be completed and submitted along with a copy of the passport.
- ☐ **Complete only if the death occurred as a result of an accident, suicide or homicide.** Further investigation will be made to confirm the circumstances surrounding the death. Please complete the enclosed Authorization to Release Information. In addition, please submit a copy of the police report, coroner's report and/or toxicology report along with a copy of the decedent's driver's license and any other relevant information that may help us complete our investigation.

Please understand your claim may be delayed if incomplete forms are submitted or if additional information is required by Foresters. We will contact you as soon as reasonably possible in the event additional information is needed. Please print clearly.

105918B CAN (06/2021)

SECTION 1: DECEDENT INFORMATION

NAME (FIRST, MIDDLE, LAST)	ANY OTHER NAMES USED

ADDRESS (STREET, CITY, PROVINCE, POSTAL CODE)

DATE OF BIRTH (MM/DD/YYYY)	DATE OF DEATH (MM/DD/YYYY)	CAUSE OF DEATH

PLACE OF BIRTH	PROVINCE OF RESIDENCE PRIOR TO DEATH

TO THE BEST OF YOUR KNOWLEDGE, HAS THE DECEASED EVER USED CIGARETTES OR ANY SUBSTANCE OR PRODUCT CONTAINING TOBACCO OR NICOTINE?

YES NO UNKNOWN

IF YES, PROVIDE DETAILS (TYPE USED, DATE LAST USED ETC.)

IF DEATH OCCURRED AS A RESULT OF AN ACCIDENT, SUICIDE OR HOMICIDE, PLEASE PROVIDE DETAILS. IF ADDITIONAL SPACE IS REQUIRED, ATTACH SEPARATE SHEET AND SIGN AND DATE.

SECTION 2: CLAIMANT'S STATEMENT AND POLICY NUMBER(S) BEING CLAIMED

LIST POLICY NUMBER(S) FOR WHICH YOU ARE MAKING CLAIM

A)	B)	C)	D)

NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP TO DECEASED
DATE OF BIRTH (MM/DD/YYYY)	SOCIAL INSURANCE NUMBER

STREET ADDRESS (STREET, CITY, PROVINCE, POSTAL CODE)

MAILING ADDRESS (STREET, CITY, PROVINCE, POSTAL CODE)

☐ STREET OR PO BOX (CHECK IF SAME AS STREET ADDRESS ABOVE)

TELEPHONE NUMBER	EMAIL ADDRESS

☐ I HEREBY AUTHORIZE FORESTERS AND/OR FORESTERS LIFE TO DELIVER THE CLAIM BENEFIT CHEQUE DIRECTLY TO THE ADVISOR OF RECORD FOR THIS POLICY, WHO WILL THEN PROMPTLY DELIVER THE BENEFIT CHEQUE TO ME.

NAME OF ADVISOR	ADDRESS OF ADVISOR

Proceeds are paid in a lump sum unless otherwise requested. For information on alternative settlement options, please contact Claims Services.

Certification, Authorization and Consent (Notarization not required)
I certify that the above answers are full and true to the best of my knowledge and belief. I hereby authorize any physician, medical practitioner, hospital, clinic, medically-related facility, government authority such as, but not limited to a provincial health insurance plan, to provide any records they may have on the deceased and I further authorize Foresters Life Insurance Company and/or The Independent Order of Foresters to share this information, if and when needed, with its reinsurers, legal counsel or other individuals or entities that may require this information in order to assist with the review of this claim and determination of benefits payable.

Fraud Notice: Any person who knowingly files a claim containing any false or misleading information is subject to criminal and civil penalties. In addition, an insurer may deny insurance benefits if false information materially related to a claim or an application for insurance was provided by the applicant or the claimant.

CLAIMANT NAME (PRINT)	CLAIMANT SIGNATURE	DATE (MM/DD/YYYY)
WITNESS NAME (PRINT)	WITNESS SIGNATURE	DATE (MM/DD/YYYY)
WITNESS ADDRESS		WITNESS PHONE NUMBER

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AUTHORIZATION TO RELEASE INFORMATION

I understand that The Independent Order of Foresters ("Foresters"), its reinsurer/s, agents, affiliates, third party administrators, or its legal counsel will require information for the purpose of establishing or reviewing the validity of the claim or for the purpose of determining whether benefits are payable and the entitlement and amounts of benefits.

I authorize any employer, physician, medical practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medical or medically-related facility, the Medical Information Bureau, insurance company, corporation, organization, institution, association, Provincial Health Insurer, or person that has any information, records or knowledge regarding the deceased, to release and exchange any and all medical records, including medical history, symptoms, treatments, examinations or diagnoses, claim information, or any other information or records that may be requested by Foresters, its reinsurers, agents, third party administrators, or its legal representatives.

I authorize any other insurance carrier, corporation, organization or person who had knowledge of this or any other claim relating to the deceased to release and exchange with Foresters or its agents any medical information, benefit payment information, or claim information that may be requested in order to allow the validity of this claim to be reviewed or for the claim to be investigated.

I understand why I have been asked to disclose this information, and am aware of the risks and benefits of consenting or refusing to consent to the disclosure of the information listed above. I understand that I may revoke this consent at any time. I also understand that if I revoke my consent, the recipient of this information will be unable to fulfil the purpose(s) stated above. I agree that a photocopy or facsimile of this authorization shall be as valid as the original. This consent is effective on the date stated below, and is valid for the duration of the claim.

NAME OF THE DECEASED ABOUT WHOM INFORMATION IS TO BE PROVIDED (PLEASE PRINT)
NAME OF THE CLAIMANT/S (PLEASE PRINT)
SIGNATURE/S OF THE CLAIMANT/S

DATE (MM/DD/YYYY)	TELEPHONE NO.

Confidentiality:
The specific and detailed information requested on this claim form is required to process and adjudicate this claim. To protect the confidentiality of this information, Foresters will establish a "Claim File" from which this information will be used to administer and process your claim. Access to this file will be restricted to those Foresters employees, mandataries, third party administrators, legal representatives or agents who are responsible for the investigation of claims, and to any other person you authorize by law. Your file is secured in our office. You can read our Privacy Policy at Foresters.com.

You may request to review the personal information in this file and make any correction in writing. To initiate the review, send a request in writing. If you would like the medical information on your file to be reviewed by a physician, send a written request with the name and address of your physician to:
Foresters, 789 Don Mills Road, Toronto, ON M3C 1T9 Attention: Claims

DATED AT	THIS	DAY OF	20
WITNESS (NOT RELATED TO CLAIMANT)		SIGNATURE OF CLAIMANT	
ADDRESS OF WITNESS			

In furnishing this or other claims forms for the convenience of the claimant the company does not admit any liability or waive any of its rights.

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PROOF OF DEATH – PHYSICIAN'S STATEMENT

POLICY #

IN THE INTEREST OF ACCURATE VITAL STATISTICS, PLEASE CONFORM TO THE INTERNATIONAL LIST OF CAUSES OF DEATH.
THE CLAIMANT IS RESPONSIBLE FOR ANY FEE FOR THIS INFORMATION

FULL NAME OF DECEASED	DATE OF DEATH (MM/DD/YYYY)
RESIDENCE AT DEATH	AGE OF DEATH
PLACE OF DEATH (IF HOSPITAL OR INSTITUTION, GIVE NAME)	
CAUSE OF DEATH (ENTER ONLY ONE CAUSE FOR DEATH FOR EACH OF (A), (B), (C) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (THIS DOES NOT MEAN THE MODE OF DYING, SUCH AS HEART FAILURE, ASTHENIA, ETC. IT MEANS DISEASE, INJURY OR COMPLICATION WHICH CAUSED DEATH). (A)	INTERVAL BETWEEN ONSET AND DEATH (A)
ANTECEDENT CAUSES (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 IN LAST ILLNESS	DATE OF LAST ATTENDANCE IN LAST ILLNESS (MM/DD/YYYY)
IF DEATH WAS DUE TO ACCIDENT, SUICIDE OR HOMICIDE, SPECIFY WHICH	WAS AN INQUEST HELD? YES NO
DESCRIBE BRIEFLY	WAS AN AUTOPSY PERFORMED? YES NO
TO THE BEST OF YOUR KNOWLEDGE, HAS THE DECEASED EVER USED CIGARETTES OR ANY SUBSTANCE OR PRODUCT CONTAINING TOBACCO OR NICOTINE? YES NO UNKNOWN	IF SO, BY WHOM AND WITH WHAT FINDINGS?
IF YES, GIVE DETAILS	

HAVE YOU TREATED OR ADVISED THE DECEASED DURING THE LAST 5 YEARS, PRIOR TO LAST ILLNESS?	YES NO
DID THE DECEASED, TO YOUR KNOWLEDGE, RECEIVE TREATMENT DURING THE LAST 5 YEARS FROM ANY OTHER PHYSICIAN, OR IN ANY HOSPITAL OR INSTITUTION?	YES NO

IF "YES" TO EITHER QUESTION, PLEASE FURNISH THE FOLLOWING:

NAME	ADDRESS	NATURE OF ILLNESS OR INJURY	DATE (MM/DD/YYYY)

SIGNATURE	DATE (MM/DD/YYYY)
ADDRESS	

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Questions or Concerns about Your Claim

At Foresters Financial™, we are committed to dealing with claims promptly and fairly. If you have any questions about your claim or our claim process, then please contact a claim representative at 800 828 1540.

If you have a concern or complaint in respect of a claim, then please contact us as soon as possible. Our claims representatives and management are often able to answer or resolve any concerns or complaints, however if they are unable to do so the the following steps are available to you:

1. You may contact our Ombudsman's Office for an independent review of your case by e-mailing us at complaints@foresters.com or contacting us by mail at:

   Foresters Financial
   789 Don Mills Road
   Toronto, ON M3C 1T9
   Attention: Office of the Ombudsman

2. If after following our internal complaint resolution process you remain dissatisfied with our final position, you can seek external assistance through the OmbudService for Life & Health Insurance (OLHI), a national independent complaint resolution service for life and health insurance consumers.

The OLHI can be reached by phone at 1-888-295-8112 or by mail at:

OmbudService for Life & Health Insurance
2 Bloor Street West # 700
Toronto, Ontario, M4W 3E2

www.olhi.ca

If you reside in Quebec, then as an alternative to OLHI, you may ask our Complaints team to transfer your file to the Autorité des marches financiers (AMF). The AMF can also be reached by phone at 1-877-525-0337 and by mail at:

Autorité des marches financiers
Service du traitement des plaintes et de l'assistance
800, square Victoria, 22e étage
C.P. 246, tour de la Bourse
Montréal (Québec) H4Z 1G3

www.lautorite.qc.ca

3. You may consult a lawyer about your claim at any time. Any person who is entitled to make a claim under our life or health insurance can begin a lawsuit with respect to the claim within 2 years of the claim arising, or the time set out in the contract, or the time permitted by law, whichever is longest. The laws with respect to limitation periods are as follows, depending on where the insurance was purchased:

- the **Insurance Act** in effect in the relevant province, for contracts governed by the laws of Alberta, British Columbia, Manitoba, New Brunswick, Nova Scotia, Prince Edward Island, Yukon, Northwest Territories, or Nunavut;
- the **Limitations Act** in effect in Saskatchewan or Newfoundland, for contracts governed by the laws of those provinces;
- the **Limitations Act, 2002,** for contracts governed by Ontario law;
- the **Civil Code,** for contracts governed by Quebec law.

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