OneMain Solutions

TYPE 0403

Underwritten by:

Triton Insurance Company
1420-380 Wellington St
London, Ontario N6A 5B5
T 800-285-8623 | Fax 877-772-2623

Involuntary Unemployment Claim Form

Insured Name:

Branch/Account Number:

Branch Mailing Address:

Date received in branch:

M M / D D / Y Y

FORM COMPLETION INSTRUCTIONS

1. Fully complete all sections and spaces on the form.
2. If a question is not applicable, a line should be drawn through the space provided for the answer.
3. Attach a copy of the Loan Protection Insurance Application, the Credit Application and Ledger Cards # 1 & 2 or the Symphony equivalent.
4. Attach copies of Employment Insurance benefit cheques or statements, covering the period of unemployment.

NOTE: Altered forms cannot be accepted.

SUBMISSION INSTRUCTIONS

1. When all required sections are complete, return the form to the office listed above.
2. Keep a copy of the entire form and any attachments for your records.
3. If the form is not fully completed with all attachments, the processing will be delayed.
4. If you choose to email the claim to InsClaims@onemainfinancial.com, please be aware email is not considered a secure method of delivery for personal/medical information.
5. Please allow 15 days after submitting for processing fully completed forms.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the applicable provincial legislation: In Alberta - *Insurance Act*; In British Columbia, New Brunswick, Nova Scotia, Prince Edward Island, Yukon, Northwest Territories and Nunavut - *Insurance Act*; In Manitoba - *The Insurance Act*; In Ontario - *Limitations Act of 2002*; In Saskatchewan and Newfoundland - *The Limitations Act*; In Quebec - *The Civil Code of Quebec*.

NOTICE REGARDING COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Triton Insurance Company collects, uses and discloses personal information about you as described: (1) in the Triton Insurance Company Privacy of Personal Information Statement (a copy of which can be obtained at the address above); (2) in *the Personal Information Authorization* section of this form; and (3) referenced in the creditor insurance application form that relates to your claim. We maintain a file containing your personal information for the purposes outlined in each of the above, accessible at 1420-380 Wellington Street London, Ontario N6A 5B5. Your file will only be accessible to employees, agents and other authorized representatives of Triton Insurance Company who are responsible for administering your file, and other persons authorized by you or by law.

By signing and submitting this claim form on your own behalf , you give your consent to the collection, use and disclosure of personal information as described above and elsewhere in this claim form, including the Personal Information Authorization section of this claim form.

SIGNATURE:

DATE: M M / D D / Y Y

PERSONAL INFORMATION AUTHORIZATION

I have read and fully understand the contents of the Notice Regarding Collection, Use and Disclosure of Personal Information ("Notice") and acknowledge and consent to Triton Insurance Company collection, use and disclosure of my personal information for the purposes identified in the Notice. For the purposes of claim investigation and processing, I hereby authorize, consent, and direct any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, employer, any workers compensation board, Human Resources and Skills Development or any other organization, institution, association or person identified in the Notice that now has or may in future have any records or knowledge concerning me or my health, employment history, benefits paid or any related information to disclose to Triton Insurance Company, their authorized representatives and reinsurers, upon the request of Triton Insurance Company any such information that is material to the purposes identified in the Notice. A photocopy of this authorization shall be as valid as the original.

SIGNATURE:

DATE: M M / D D / Y Y

1. STATEMENT OF INSURED Print or Type All Information. To be completed, signed and dated by the insured.

Employer's name:

Telephone #: ___ - ___ - ____

Employer's complete mailing address:

Prov.:

Postal Code

Occupation: ☐Full Time ☐Part Time ☐Seasonal ☐Other _____

Total hours per week:

Reason for stopping work: ☐Non-Seasonal Lay-off / Shortage of Work ☐Seasonal Lay-off ☐Lock-out ☐Annual or Regularly-Scheduled Shutdown ☐Employer Termination ☐End of Contract ☐Other _____

Date of hire: MM / DD / YY

Date last worked: MM / DD / YY

Did you receive severance pay? ☐Yes ☐No

Date 1st notified of separation: MM / DD / YY

Registered for: ☐Regular EI benefits ☐Medical EI benefits ☐Not Registered for EI benefits

Date of registration: MM / DD / YY

Date 1st payment approved by EI: MM / DD / YY

Date you returned to work: MM / DD / YY

If returned to work, days per week:

Hours per day: Y

I certify that the foregoing statements, including any accompanying statements, are true, correct and complete to the best of my information, knowledge and belief.

SIGNATURE:

DATE: MM / DD / YY

COMPLETE MAILING ADDRESS:

CITY:

PROV.:

POSTAL CODE:

2. STATEMENT OF MOST RECENT EMPLOYER To be completed by your most recent employer.

Date of hire: M M / D D / Y Y

Date last worked: M M / D D / Y Y

Hours per week:

Months worked:

Job title; If sole proprietor, owner or partner indicate:

Type of employment: ☐Full Time ☐Part Time ☐Seasonal ☐Temporary

Reason for stopping work:
☐Non-Seasonal Lay-off / Shortage of Work
☐Seasonal Lay-off
☐Lock-out
☐Annual or Regularly-Scheduled Shutdown
☐Employer Termination
☐End of Contract
☐Other _____

Estimated return to work date: M M / D D / Y Y

Has the person experienced previous interruption(s) in employment of 30 days or more? ☐Yes ☐No If yes,

From:	Through:	Reason:
M M / D D / M M	D D / M M / Y Y	
M M / D D / M M	D D / M M / Y Y	
M M / D D / M M	D D / M M / Y Y	

COMPANY NAME:

TELEPHONE #: - -

COMPLETE MAILING ADDRESS:

CITY:

PROV.:

POSTAL CODE:

SIGNATURE OF INDIVIDUAL COMPLETING:

DATE: M M / D D / Y Y

PRINTED NAME:

TITLE: