OneMain Solutions

TYPE 0401

Underwritten by:
American Health and Life Insurance Company
1420-380 Wellington St
London, Ontario N6A 5B5
T 800-285-8623 | Fax 877-772-2623

Life Claim Form

Insured Name:

Branch/Account Number:

Branch Mailing Address:

Date received in branch:

M M / D D / Y Y

FORM COMPLETION INSTRUCTIONS

1. Attach the following documents.
   - ☐ A copy of the loan protection insurance application.
   - ☐ Black and white screen prints of pages 1 and 2 of the ledger card screen.
   - ☐ A black and white death claim payoff inquiry as of the date of death.
   - ☐ If Section III is not completed, a copy of the certified Death Certificate, Coroner's report or funeral director's statement.

2. If the insurance certificate contained a health question or statement, have the deceased's next-of-kin complete the Next-of-Kin Authorization.

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

The information previously provided to American Health and Life Insurance Company by the insured, and collected on this form, is used and disclosed for the purpose of evaluating, assessing, investigating and processing this claim, and otherwise as described in our Privacy Policy (a copy of which you may obtain by contacting us at the address above) and in the creditor insurance application form submitted by the insured.

We will not request genetic test results and if received inadvertently, we will not use genetic test results to determine eligibility for coverage or to determine claim benefits.

We maintain a file containing the insured's personal information for the purposes outlined above, accessible at 1420-380 Wellington Street London, Ontario N6A 5B5. The file will only be accessible to employees, agents and other authorized representatives of American Health and Life Insurance Company who are responsible for administering the file, and other persons authorized by the insured or by law. Subject to exceptions set out in applicable legislation, persons with legal authority may access the insured's file and request corrections to the insured's personal information by sending a written request to Privacy Officer, at 1420-380 Wellington Street London, Ontario N6A 5B5.

NEXT-OF-KIN AUTHORIZATION - To be completed by the deceased's next-of-kin, if the insurance certificate contained a health question or statement. Give the name(s), complete address(es) and telephone number(s) of any physician, hospital or other person who has attended the deceased insured and any pharmacy that filled a prescription for the deceased insured within the past 5 years.

NAME	FULL ADDRESS	TELEPHONE NUMBER

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 American Health and Life Insurance Company collection, use and disclosure of _____'s personal information 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 _____ or _____'s health, employment history, benefits paid or any related information to disclose to American Health and Life Insurance Company, their authorized representatives and reinsurers, upon the request of American Health and Life Insurance Company information 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.

NEXT OF KIN SIGNATURE: DATE: M M / D D / Y Y

RELATIONSHIP TO INSURED

COMPLETE MAILING ADDRESS: CITY: PROV.: POSTAL CODE:

If signed by a personal representative of the Insured

Address: Telephone # :

Printed name of personal representative: Relationship/authority to sign for insured:

STATEMENT OF ATTENDING PHYSICIAN To be completed by the Attending Physician OR coroner. Any fee for completion of this claim form is responsibility of the Estate.

Date of death: M M / D D / Y Y

Date of birth: M M / D D / Y Y

Place of death:

Cause of death (disease or condition directly leading to death):

Death due to consequence of:

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

Death due to:

O Natural O Accident O Suicide O Other (please explain)_____

Was death caused by or contributed to by the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? O Yes O No

Have you advised, consulted or treated the deceased during the past 3 years? O Yes O No

Date deceased was informed of diagnosis: M M / D D / Y Y

Family doctor's name:

Complete mailing address: City Province: Postal code:

Printed name of attending physician or coroner: Telephone #: - -

Complete mailing address: City Province: Postal code:

Signature of attending physician or coroner: Date: M M / D D / Y Y