

Name Account # Claim #
(if applicable)

Involuntary Unemployment Claim Form

NOTICE

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
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D	D
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Y	Y
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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
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D	D
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Y	Y
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INSTRUCTIONS

1. When all required sections are complete, return the form to the office listed above.
2. Attach a copy of the Loan Protection Insurance Application, the Credit Application and most recent transaction history.
3. Keep a copy for your records. Please be aware email is not considered a secure method of delivery for personal/medical information.

Note: Altered forms cannot be accepted.

Name _____ Account # _____ Claim # _____
(if applicable)

Involuntary Unemployment Claim Form - Statement of Insured - To be completed by Insured

Date of birth

M	M
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D	D
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 /

Y	Y
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Complete mailing address _____ City _____ Province _____ Postal Code _____

Employer's name _____ Telephone # _____

Employer's complete mailing address _____ City _____ Province _____ 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

M	M
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D	D
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 /

Y	Y
---	---

 Date last worked

M	M
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 /

D	D
---	---

 /

Y	Y
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Did you receive severance pay? Yes No Date 1st notified of separation

M	M
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 /

D	D
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 /

Y	Y
---	---

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

Date of registration

M	M
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D	D
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 /

Y	Y
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 Date 1st payment approved by EI

M	M
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 /

D	D
---	---

 /

Y	Y
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Date you returned to work

M	M
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 /

D	D
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 /

Y	Y
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 If returned to work, days per week _____ Hours per day _____

I affirm the information I have provided herein is accurate and complete.

Signature _____ Date

M	M
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 /

D	D
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 /

Y	Y
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Name _____ Account # _____ Claim # _____
(if applicable)

Involuntary Unemployment Claim Form - Statement of Employer - To be completed by Employer

Date of hire

M	M
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 /

D	D
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 /

Y	Y
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 Date last worked

M	M
---	---

 /

D	D
---	---

 /

Y	Y
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Job title; If sole proprietor, owner or partner indicate _____ Hours per week _____ Months worked _____

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 _____

Type of employment Full Time Part Time Seasonal Temporary Estimated return to work date

M	M
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 /

D	D
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 /

Y	Y
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Has the person experienced previous interruption(s) in employment of 30 days or more? Yes No If yes,
From _____ Through _____ Reason _____

Employer representative's signature _____ Date

M	M
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D	D
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Y	Y
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Printed name _____ Title _____

Company name _____ Telephone # _____

Complete mailing address _____ City _____ Province _____ Postal Code _____