

# LIFE BENEFIT CLAIM BUSINESS LOAN INSURANCE PLAN



Group Policy 51000

- Instructions :
1. Complete Sections 2 & 3 if death occurs within 2 years of any advance of funds or of completion of an Application for Insurance.
  2. Attach: Original or certified true copy of Death Certificate or Funeral Director's Statement; Original copies of all Applications for Insurance.
  3. Please send all documents to: Insurance Service Centre, P.O. Box 53, Postal Station A, Mississauga, Ontario L5A 2Y9 Transit #04523.
  4. If you have any questions, call the Insurance Service Centre toll-free at: 1-800-ROYAL 2-3 or 1-800-769-2523.
  5. The Insurance Service Centre will add information about the insured loans to these documents and send them to the Insurer.

## Section 1 - General Information

Business Name		Name of Contact		
Address				
Business SRF No.	Telephone No.	Fax No.	Transit No.	Loan No.

Account Manager	Telephone No.	Fax No.
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Deceased's First Name/Initials		Deceased's Last Name		
Address				
Personal SRF No.	Date of Birth (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)	Life Insurance Amount	
Cause of Death				

## Section 2 - Physician's Statement

Deceased's Name in Full	Date Last Illness Began (mm/dd/yyyy)
_____	___/___/___
Place of Death	Date of Death (mm/dd/yyyy)
_____	___/___/___
Immediate Cause of Death	Was death due to (X) <input type="checkbox"/> Natural Causes <input type="checkbox"/> Suicide
_____	<input type="checkbox"/> Accident <input type="checkbox"/> Homicide
Contributory Cause of Death	
_____	

If death is other than natural causes, please provide details along with a copy of the Police, Fire or Coroner's reports.

To the best of your knowledge, has the deceased ever used any tobacco products?	Yes (X) <input type="checkbox"/>	No <input type="checkbox"/>	Yes, but stopped on ___/___/___ (mm/dd/yyyy)
Did you treat or advise the deceased during the 5 year period preceding death?	Yes (X) <input type="checkbox"/>	No <input type="checkbox"/>	

If yes, please provide details (dates, illness/injury): \_\_\_\_\_

Did the deceased, to your knowledge, receive treatment during the last <u>5 years</u> from any other physician, Health practitioner, or in any hospital or institution? If yes, please provide details:	Yes (X) <input type="checkbox"/>	No <input type="checkbox"/>
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Date	Name of physician/hospital	Address	Details

Name of Physician (print name)	Telephone No.	Fax No.
Address	City or Town	Province
		Postal Code

To the best of my knowledge and belief, the above statements are true and complete.	Signature of Physician	Date (mm/dd/yyyy)
	_____	___/___/___

**LIFE BENEFIT CLAIM  
BUSINESS LOAN INSURANCE PLAN**



Business Name

Name of Contact

Deceased's First Name/Initials

Deceased's Last Name

**Section 3 - Next of Kin's Statement**

State your relationship to the deceased

To the best of your knowledge, has the deceased ever used any tobacco products? (X)  Yes  No  Yes, but stopped on     /    /      
(mm/dd/yyyy)

What date did the deceased first complain of, or consult a physician for, his/her last illness?     /    /      
(mm/dd/yyyy)

Names and addresses of attending physicians of the deceased and hospitals where deceased was treated during the 5 years prior to death.

Print Name	Address	Date (mm/dd/yyyy)	Medical Condition

I authorize Sun Life Assurance Company of Canada, the plan administrator(s), and their advisors and service providers to collect, use and exchange information needed for underwriting, administration and adjudicating claims under this insurance coverage relating to \_\_\_\_\_ (the life insured) with any person or organization who has relevant information pertaining to this claim including health professionals, government agencies, provincial health care plans institutions, investigative agencies, insurers and reinsurers.

I understand that information pertaining to this claim may be reviewed in the event that this plan is audited.

A photocopy or electronic version of this authorization shall be as valid as the original.

Name of Next of Kin (print name)	Signature of Next of Kin	Date (mm/dd/yyyy) <u>    </u> / <u>    </u> / <u>    </u>
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