

CLAIM INQUIRY FORM

* Indicates required field

Please do not retain copies of any claim documentation you may have in your possession for this client in keeping with Privacy Guidelines.

Section 1

* Advisor Name and/or MGA Name		Advisor Code and/or MGA Code
* Phone Number	Email Address	
<input type="checkbox"/> Life Insurance Claim (Complete Section 2)	<input type="checkbox"/> Critical Illness Insurance Claim (Complete Section 3)	<input type="checkbox"/> Disability Insurance Claim (Complete Section 4)

Section 2 - Life Insurance Claim

* Insured's Name		* Policy Number
<i>Details where forms should be sent</i>	Name of recipient (if other than advisor/MGA)	Telephone Number
	Address of recipient	
* Date of Death (dd/mm/yyyy)	* Cause of Death (if known)	
* Place of Death		
Additional Comments:		

Section 3 - Critical Illness Insurance Claim

* Insured's Name		* Policy Number
<i>Details where forms should be sent</i>	Name of recipient (if other than advisor/MGA)	Telephone Number
	Address of recipient	
* Diagnosis		
Additional Comments:		

Disclaimer: While we will provide the insured with a diagnosis specific claim form to assist in their application for benefits, please note that only conditions covered by your policy will be considered. We encourage you to review the policy with the insured regarding the covered conditions.

Section 4 - Disability Insurance Claim

* Insured's Name		* Policy Number
<i>Details where forms should be sent</i>	Name of recipient (if other than advisor/MGA)	Telephone Number
	Address of recipient	
Additional Comments:		

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