Mortgage Life Insurance Claim
Creditor Insurance – Policy no. 51007

BMO Bank of Montreal Representative:

Last name (print)	First name (print)
Signature X	Email address
Telephone number – –	Fax number – –
Date (dd-mm-yyyy) – –	

Branch Domicile Stamp

What information is required for a Life Claim?

Checklist:

- **If death occured more than 2 years after the date of commencement of this insurance, the complete claim package consists of:**
  - ☐ Bank's statement (page 2-3)
  - ☐ Original Funeral Director's certificate of death OR certified copy of the official death certificate
  - ☐ Statement of Authorized Representative (page 4) (completed and signed by the deceased's estate representative
- **If death occured less than 2 years after the date of commencement of this insurance, the complete claim package consists of:**
  - ☐ Bank's statement (page 2-3)
  - ☐ Statement of Authorized Representative (page 4) (completed and signed by the deceased's estate representative). Please attach a copy of the deceased's Last Will.
  - ☐ Physician's Statement (page 5) (completed and signed by the physician who was responsible for the deceased prior to the deceased's death)
  - ☐ Original Funeral Director's certificate of death OR certified copy of the official death certificate

To ensure your claim is processed promptly:

- Ensure that all required forms are fully completed and returned as soon as possible.
- Return completed package in a sealed envelope (except the Bank's statement) to your branch. Your branch will forward the claim package to the insurer on your behalf.
- Sun Life Assurance Company of Canada can only process your claim once we have received all the above documents fully completed. To prevent delays, please be sure the forms are completed in full and provide as much information as possible to help with the adjudication of your claim.
- For questions about your claim, you may call Sun Life Assurance Company of Canada at 1-877-271-8713.

Important notes:

- For deaths that occur outside North America, additional documentation may be required, Sun Life Assurance Company of Canada will contact you.
- Sun Life Assurance Company of Canada will inform you if your claim is subject to further investigations.
- Until Sun Life Assurance Company of Canada advises you in writing of the decision of the claim, it is the deceased estate's responsibility to continue the mortgage payments.
- Proof of claim must be submitted within 1 year of date of death.
- Any required proof relating to a claim is at the expense of the representative submitting the claim.
- Retain a copy of the claim package for your records.

Sun Life Assurance Company of Canada is a member of the Sun Life Financial group of companies.

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Bank's Statement

Instructions

1. Sections 1, 2 and 3 to be completed by the Bank of Montreal Branch
2. Attach a copy of all Mortgage Insurance Application(s) pertaining to this claim
3. Give the entire claim package to the estate representative to complete
4. Advise the estate representative to return the claim package in a sealed envelope (except for the Bank's Statement) to the Branch
5. Send the completed claim package in a sealed envelope along with the Bank Statement to the Mortgage Service Centre (MSC) for completion of Section 4 & 5

1 Insured's information

First name	Last name	☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr.	Language ☐ English ☐ French
Date of birth (dd-mm-yyyy)	Date of death (dd-mm-yyyy)	Telephone number	
Address (street number and name)			Apartment or suite
City	Province		Postal code

2 Mortgage information

Mortgage number	Effective date of insurance (dd-mm-yyyy)	
Is this mortgage ☐ New	☐ Refinanced – If refinanced, was it previously insured? ☐ Yes ☐ No ☐ Pre-approved mortgage – If "Yes", what is the closing date (dd-mm-yyyy)	
Authorized amount $	Were premiums paid up to date at time of death? ☐ Yes ☐ No If "No", state due date of last premiums paid (dd-mm-yyyy)	
Balance at date of death $	Percent of balance covered ☐ 50 % ☐ 100% ☐ Other	Coverage status ☐ Active ☐ Ineligible ☐ Approved ☐ Waived ☐ Pending

3 Lender information

First name	Last name	
Telephone number	Transit number	Current date (dd-mm-yyyy)

I am an authorized representative of the bank and hereby certify that the above information is true and correct.

Signature of lender X	Title

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4 Mortgage information – to be completed by the Bank of Montreal Mortgage Service Centre

Principal outstanding	$
Unpaid Interest	$
Principal and unpaid interest owing	$
Amount of debit of tax account	$
Accrued debit interest on tax account	$
Amount owing as of date of death	$
Bonus payable	$
Discharge fee	$
Total amount owing as at date of death	$
Per diem interest	$

5 Bank of Montreal Mortgage Service Centre Representative

I am an authorized representative of the Bank of Montreal Mortgage Service Centre and hereby certify that the above information is true and correct.

Dated at (dd-mm-yyyy)	Authorized representative	Title
– –	X	

Address (street number and name)	Telephone number
	– –

City	Province	Postal code

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Statement of Authorized Representative

Date the deceased first complained or gave other indication of his/her last illness (dd-mm-yyyy)	Date the deceased first consulted a physician for his/her last illness (dd-mm-yyyy)
Immediate cause of death:	

If death occurred as a result of an accident, please provide details:

Please provide the name and address of deceased's family physician:

Last name of family physician	First name	
Address (street name and number)		Apartment or suite
City	Province	Postal code

Please provide the names and addresses of all physicians and all hospitals where the deceased received treatment during the five years prior to death:

First name	Last name	Address
Disease or condition	Dates	

First name	Last name	Address
Disease or condition	Dates	

First name	Last name	Address
Disease or condition	Dates	

I certify that the information is true and correct. I authorize Sun Life Assurance Company of Canada, the plan administrator(s), and their agents and service providers to collect, use and disclose information needed for underwriting, administration and adjudicating claims under this insurance policy 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.

I agree that a photocopy of this authorization or electronic version is as valid as the original and shall remain in effect for the continued administration of this policy.

Name of deceased's authorized representative	Relationship to deceased (e.g., next of kin, executor/executrix, etc.)	
Address (street name and number)		Apartment or suite
City	Province	Postal code
Signature of authorized representative X		Date (dd-mm-yyyy)

Respecting your privacy

Your privacy is important to us. We may leverage our strengths in our worldwide operations in our negotiated relationships with third-party providers to help us service some of our customers. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by email to ***privacyofficer@sunlife.com***, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

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Physician's Statement

This section must be completed in all cases where death occurred less than 2 years after the date of commencement of this insurance.

Deceased's last name	First name	
Date illness began (dd-mm-yyyy) – –	Date of death (dd-mm-yyyy) – –	Place of death
Immediate cause of death		
Contributory cause of death		

Was death due to ☐ Natural causes? ☐ Suicide? ☐ Accident? ☐ Homicide?

If death occurred as a result of an accident, please provide details:

Have you treated or advised the deceased during the last 3 years? ☐ Yes ☐ No If *yes*, please provide following:

Disease or condition	Dates
Disease or condition	Dates
Disease or condition	Dates

Attach extra sheets, if necessary.

Did the deceased, to your knowledge, receive treatment during the last 3 years from any other physician, health practitioner, or in any hospital or institution? ☐ Yes ☐ No If *yes*, please provide following:

First name	Last name	Address
Disease or condition	Dates	

First name	Last name	Address
Disease or condition	Dates	

First name	Last name	Address
Disease or condition	Dates	

I certify that the information is true and correct.

Name of physician		
State qualifications		
Address (street name and number)		Apartment or suite
City	Province	Postal code
Signature of physician X		Date (dd-mm-yyyy) – –