American Health and Life Insurance Company
1420-380 Wellington Street
London, Ontario N6A 5B5
Toll Free 800-285-8623 | Fax 877-772-2623 | insclaims@omf.com

Insured's Name: ______________________ **Claim Number:** ____________ ___

Account Number: ___________________________________

Claim Form for Reporting a Death

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

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 or on our website at www.americanhealthandlife.ca) and in the creditor insurance application form submitted by the insured.

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.

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Insured's Name: ________________________ **Claim Number:** _____________ ___

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Claim Form for Reporting a Death - Instructions

1

❑ 1. Attending Physician's Section should be completed, signed, and dated by deceased insured's attending physician or coroner. In lieu of this completed section, one of the following may be submitted:
- Copy of coroner's report; or
- Copy of certified death certificate; or
- Copy of funeral director's statement

Note: Cause and manner of death may be required based on date of death.

❑ 2. Lender must submit:
- A copy of the Loan Protection Insurance Application; **and**
- A black and white copy of the transaction history showing the last payment prior to the date of death and all transactions since that date; **and**
- A black and white death claim payoff inquiry screen print as of the date of death.

2

- Depending on the Insurance Certificate's requirements, additional claim information may be required.
- It is important to submit fully completed, signed, and dated claim forms to avoid delays in processing this claim. Altered claim forms may not be accepted.
- Keep a copy for your records. Please be aware email is not considered a secure method of delivery for personal/medical information.

3

Please return the completed claim form and supporting documents to us in one of the following ways:

Email: insclaims@omf.com
Please be sure to include the insured's name and account number/claim number in the subject line of your email.

Upload online:
www.americanhealthandlife.ca

Mail: American Health and Life Insurance Company
1420-380 Wellington Street
London, Ontario N6A 5B5

Fax: 877-772-2623

We are here to help!

Our Customer Solutions team is available to assist you
Monday through Friday, 8:00 am to 8:00 pm ET.

Toll free:
800-285-8623

Chat:
www.americanhealthandlife.ca

(05-2023) CNE Life

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Insured's Name: ________________________ **Claim Number:** _____________ ___

Account Number: ______________________________________

Claim Form for Reporting a Death Attending Physician's Section - To be completed by attending physician or coroner. Completed without expense to the insurance company.			
Date of death (mm/dd/yy)		Date of birth (mm/dd/yy)	
Place of death			
Cause of death (disease or condition directly leading to death)			
Death due to ❑ Natural ❑ Accident ❑ Suicide ❑ Under investigation ❑ Other, please state ______________________________			
Family doctor's name			
Family doctor's mailing address	City	Province	Postal Code
Printed name of attending physician or coroner		Telephone number	
Attending physician/coroner's mailing address	City	Province	Postal Code
Signature of attending physician/coroner		Date (mm/dd/yy)	