PRIMERICA LIFE INSURANCE COMPANY OF CANADA

HEAD OFFICE: 6985 Financial Dr. Suite 400, Mississauga, Ontario L5N 0G3

CLAIM INSTRUCTIONS

1. Please review these Claim Instructions carefully. We will need to receive the completed forms and other supporting documentation described in these Claim Instructions in order to proceed with your claim. If you need help with filing your claim, please call 1-800-387-7876.

2. The Claimant's Statement on pages four and five must be completed by the beneficiary of record. **The signature must be witnessed.** If there is more than one beneficiary, a separate Claimant's Statement must be completed by each beneficiary.

3. When the beneficiary is a minor, incapacitated, or is unable to sign page four, the person empowered to act for the beneficiary must sign the Claimant's Statement. **The signature must be witnessed.** ***(Please attach supporting documents; i.e. Power-of- Attorney, Certified Letter of Guardianship)***. The Claimant's Statement must include the Social Insurance Number of the minor child or incapacitated beneficiary.

4. When the beneficiary is the estate, the Executor or Administrator of the Estate of the deceased must complete the Claimant's Statement. If the benefit amount is over $25,000 a Certificate of Appointment of Estate Trustee With or Without a Will or Letters Probate must be provided. If $25,000 or less, a certified copy of the will must be provided.

5. The Physician's Statement on page six must be completed by the family physician or the physician who recently treated the insured. ***Any fees associated with the completion of this form, is the responsibility of the claimant.***

6. The original or a certified copy of the death certificate from the funeral home or the province must be provided to us.

7. All documents sent to us, including but not limited to the original or certified copy of the death certificate, become a part of the claim file and ***cannot be returned to you***.

8. The Authorization and Consent on page two must be completed by the next of kin of the deceased. If the deceased was married at the time of death, the spouse should complete the Authorization and Consent. If the deceased was not married at the time of death, a parent or closest next of kin should complete the Authorization and Consent.

9. If any primary beneficiary named in the policy has died before the insured, a copy of the death certificate of the primary beneficiary must be attached.

10. If the insured died outside of Canada a "Foreign Claims Questionnaire" must be completed. Primerica will conduct a verification of the death.

11. The Claim Payment Options Form must be completed to select your method of payment.

Thank you for your patience. This important information will help us greatly. Primerica Life Insurance Company of Canada is committed to following the fair treatment of customer principles prescribed by the Canadian Council of Insurance Regulators, the Canadian Insurance Services Regulatory Organizations, and various provincial regulators. Towards that goal, we will strive to examine your claim diligently and fairly, using a simple and accessible procedure.

A routine claim investigation is conducted on all claims where death is within two years of policy issue or reinstatement. Claim investigations may also be conducted where death is beyond two years of policy issue or reinstatement. The investigation is usually completed within 30 to 60 days after receipt of the completed claim forms and proper authorization to obtain information. Subject to availability of records, a claim investigation may take longer to complete. If we approve a claim, we expect that payment would be issued within 14 business days; however in some instances, payment may take longer. You can request that payment be issued to you in a lump sum by cheque, that your payment be deposited directly into an investment account with the Primerica companies for you, or a combination of both. Please see page 3 of this claim form for more information on claim payment options. If you have any questions about our claim process, please call 1-800-387-7876.

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CLAIM #: ____________________

AUTHORIZATION AND CONSENT

I, ____________________________________, am the next of kin of __________________________________ (the "Deceased Insured").
Print Name of Next of Kin — Print Name of Deceased Insured

In my capacity as next of kin of the Deceased Insured, I authorize any health care professional, public health or social services establishment, hospital, insurance company, financial institution, the Medical Information Bureau, insurer, market intermediary, personal information agent or detective and/or security agency, any employer, former employer, and any public or private body holding Personal Information regarding the Deceased Insured to provide such information to Primerica Life Insurance Company of Canada (the "Insurer"), its agents, representatives, employees and its reinsurers, for the purpose of the investigation and adjudication of this life insurance policy claim (the "Claim"). "Personal Information" includes, but is not necessarily limited to all information about the Deceased Insured, including medical information such as diagnoses, treatments and prognoses with respect to any physical or mental conditions of the Deceased Insured, as well as use of drugs and alcohol. I understand that Personal Information may also be obtained by the Insurer from consumer reports about the Deceased Insured containing information concerning habits, character, general reputation, personal characteristics and lifestyle, except relating to sexual orientation. Personal Information also may be obtained through personal interviews with anyone including but not limited to neighbours, friends and acquaintances.

I ALSO AUTHORIZE the Insurer, its agents, representatives, employees and its reinsurers to make inquiries and obtain the Deceased Insured's Personal Information related to this Claim from any health care professional, public health or social services establishment, hospital, insurance company, financial institution, the Medical Information Bureau, insurer, market intermediary, personal information agent or detective and/or security agency, as may be necessary for the purposes of investigating and adjudicating this Claim.

I FURTHER AUTHORIZE the Insurer, its agents, representatives, employees and its reinsurers to share the Deceased Insured's Personal Information related to this Claim with any health care professional, public health or social services establishment, hospital, insurance company, financial institution, the Medical Information Bureau, insurer, market intermediary, personal information agent or detective and/or security agency, as may be necessary for the purposes of investigating and adjudicating this Claim.

I UNDERSTAND that the duration of this Authorization and Consent is for the duration of all claims related to the life insurance policy that is the subject of this Claim.

A photocopy of this Authorization and Consent has the same value as the original.

Signed this__________________________ day of ________________________________, ____________________________

_________________________________ _______________________________
Signature of Next of Kin — Witness

____
Relationship to Deceased Insured

Address:____
Street Address, City, Province, Postal Code

Phone Number: ____________________

PRIVACY AND PERSONAL INFORMATION DISCLOSURE

Personal Information obtained by use of this Authorization and Consent will be stored in a claims file at the Insurer's Head Office and will be used by the Insurer or its agents, representatives, employees and reinsurers to determine eligibility for benefits under the life insurance policy that is the subject of this Claim.

You may access written information about the Insurer's policies and practices governing privacy and personal information by reviewing the Primerica Canada Privacy Code at: http://www.primericacanada.ca/public/canada/canada_privacy.html. You may also contact our Privacy Officer at privacyofficecanada@primerica.com. For additional information and questions about our privacy practices, you may write to us c/o Privacy Officer at PO Box 174, Streetsville, Ontario L5M 2B8. Please include your full name and policy number with your request.

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CLAIM #: __________________

Claims Payment Options

If Primerica Life Insurance Company of Canada ("Primerica") approves your claim, you can choose one of three options for receiving your payment:

1) Your payment is issued to you by way of a lump sum cheque;
2) Your payment is deposited into either a new or existing investment account with Primerica or through Primerica's affiliate PFSL Investments Canada Ltd ("PFSL")*; or
3) Your payment is issued to you partially by way of a lump sum cheque and partially deposited into a new or existing investment account with Primerica or through PFSL*.

* For any mutual fund accounts through PFSL, your Primerica agent must hold a mutual fund registration in order to advise you on mutual fund products.

Please make your selection below. Please note that you can change your mind at any time regarding the payment method by advising Primerica in writing before the payment is made by Primerica.

For any option involving a payment issued by way of lump sum cheque, your Primerica agent will hand deliver a cheque to you if your claim is approved. If the agent is unable to hand deliver it to you, the cheque will be mailed directly to you.

For any option involving a payment deposited into an investment account, your Primerica agent will meet with you to review your investment needs. The investment account must be solely owned by you. For a mutual fund account, your Primerica agent must hold a mutual fund registration in order to advise you on mutual fund products. If your claim is approved, the payment will be deposited in your investment account once you have either completed an application to open a new account or have signed a subsequent contribution form for an existing account with your Primerica agent.

How would you like to receive the claim amount? (choose one of the Claims Payment Options below)
Option 1: Entire amount by cheque ☐ I wish to receive the entire amount by way of a lump sum cheque.
Option 2: Full deposit into my investment account ☐ I wish to transfer the entire amount to my Primerica / PFSL investment account with ____________________ (fund company) into account number _________________. **For a new account, enter "New Account" in the account number field**
Option 3: Partial deposit into my investment account, remainder by cheque ☐ I wish to transfer $ ______________________to my Primerica / PFSL account with ____________________ (fund company) into account number ________________. The remainder is to be paid to me by way of lump sum cheque. **For a new account, enter "New Account" in the account number field**

I hereby authorize and direct Primerica to issue payment to me according to the Claim Payment Option I have selected above. I understand that my completion of this Claim Payment Option form does not in any way imply that Primerica has or will approve my claim for payment under the above noted Claim # or that I am entitled to any payment under the subject life insurance policy. I acknowledge that: Primerica, by complying with the Claim Payment Option I have selected above, has fulfilled all payment obligations related to the above-noted Claim #, Primerica has satisfied all obligations to me as a beneficiary of the subject life insurance policy, and that Primerica is discharged once the payment is made. I understand that if I choose to direct Primerica to complete my payment by depositing the funds in an investment account, that commissions, trailing commissions, taxes, management fees and expenses may apply to the funds deposited in the investment account. Further, I understand that funds deposited in an investment account are not covered by the Canada Deposit Insurance Corporation or by any other government deposit insurer. I understand that the value of the funds deposited into the investment account may fluctuate and decrease. I understand that I must review the prospectus or information folder (as applicable) before making a final decision regarding investing.

IN WITNESS WHEREOF this Authorization and Direction has been signed by ______________________________ on the
Print name of Claimant
_______day of ____________, ____

SIGNED, SEALED AND DELIVERED in the presence of:

______________________________ Signature of Witness

______________________________ Signature of Claimant

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CLAIMANT'S STATEMENT

**** Please Attach a Certified Copy of the Death Certificate ****

1. Deceased's Name in Full ______________________________

2. Policy Number(s)______________________________

3. Deceased's Birth Date ____________________ Source from which Birth Date Obtained ____________________
Birth Certificate, Family Record, Other Record

4. Residence of Deceased at Death______________________________
Street Address *City* *Province* *Postal Code*

5. Date of Death ____________________ Place of Death ____________________

6. Cause of Death____________________ 7. What is your relationship to the Deceased? ____________

8. Employer of Deceased____________________ Deceased's Occupation ____________________

9. Did the deceased ever smoke or use tobacco products? ☐ Yes ☐ No If yes, when last used_____/_____/_____
MM DD YYYY

Did the deceased ever stop smoking? ☐ Yes ☐ No If so, when and for how long? ____________________

10. To the best of your knowledge, list names of physicians who treated the deceased in the past ten years

Name	Address	Nature of Illness or Injury	Date

11. If deceased has insurance with other companies, list names of companies and amounts below.

Name of Companies	Amounts

12. Marital Status of Deceased ____________________ Spouse's Name ____________________

Children of Deceased ____________________ Spouse's Address____________________

____________________ ____________________

The furnishing of this form or its acceptance by the Company must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

The **Claimant Information** on the reverse side ***must*** be filled out completely in order to avoid any delay.

CLAIMANT INFORMATION - *Please Print or Type* ***(Must Be Completed)***

All information in this section *must* be completed and *must* pertain to the Claimant.

Name:____

Print Name as it should appear on cheque - Attach proof of name change, if applicable.

Address:____

Street Address (No P.O. Box)

____

City Province Postal Code

Telephone Numbers:

Home: (   ) _______________________ Work: (   ) _______________________

Area Code Phone Number Area Code Phone Number

Social Insurance Number:_______________________ Date of Birth of Claimant:_______________________

Individual - Claimant's Social Insurance Number
Guardianship - Child's Social Insurance Number

Under the penalties of perjury, I certify that (1) the number shown on this form is my correct taxpayer identification number, and (2) all answers on this form (ZPLA-880) are correct and true.

CLAIMANT AND WITNESS SIGNATURE

Signature of Claimant ✗ ____

Sign name as printed above in the Claimant Information Section

Signed this _______________________ day of _______________________, 20__________

Name of Witness ____

Address and Phone Number of Witness ____

Street Address

____ (   ) _______________________

City Province Postal Code Area Code Phone Number

____

Signature of Witness Relationship to Beneficiary

Signed this _______________________ day of _______________________, 20__________

PHYSICIAN'S STATEMENT

The Claimant is responsible for any fees related to the completion of this form

Full name of deceased	Date of death
Residence at death	Place of death
Age at death or date of birth	(If Hospital or Institution, give name)

Cause of death	Interval between onset and death
Disease or condition directly leading to death: (This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complications which caused death.)	
(a)	(a)
Antecedent causes. (Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.)	
Due to (b)	(b)
Due to (c)	(c)
Other significant conditions: (Contributing to the death but not related to the disease or condition causing death.)	

Date of First Attendance in Last Illness	Date of Last Attendance in Last Illness

Did the deceased ever smoke or use tobacco products? ☐ Yes ☐ No If yes, when last used____/____/____ (MM DD YYYY)

Did the deceased ever stop smoking? ☐ Yes ☐ No If so, when and for how long? ____/____/____ (MM DD YYYY)

If death was due to accident, suicide or homicide, specify which. Describe briefly.	Was an inquest held? ❑ Yes ❑ No Was an autopsy performed? ❑ Yes ❑ No If so, by whom and with what findings?____________

Have you treated or advised the deceased during the last 5 years, prior to last illness? ❑ Yes ❑ No

Did the deceased, to your knowledge, receive treatment during the last 5 years from any other physician, or in any Hospital or Institution? ❑ Yes ❑ No

If YES to either question, please furnish the following:

Name	Address	Nature of Illness or Injury	Dates

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

______________________M.D. ______________________
Physician's Signature Print Signing Physician's Name

____
Street Address

____
City Province Postal Code

______________________ ______________________
Area Code Phone Number Date