Group Life Benefit Claim for Accidental Dismemberment or Specific Loss

PART 1 EMPLOYER'S OR ADMINISTRATOR'S STATEMENT

Name of Employee: _____ Employee Phone No.: _____

Address: _____

Group Policy No.: _____ Certificate No.: _____ Division No.: _____

Total amount of insurance coverage: $_____ Date of Birth: _____

Amount of Accidental Dismemberment or Loss Benefit: $_____ Date last reported for work prior to accident: _____

Salary or wages as of date last reported for work: $_____ Has the employee returned to work? ☐ Yes ☐ No

If reason for leaving was other than the accident please give details. _____

_____

_____

Date of employment: _____ Name of Group: _____
EMPLOYER OR ASSOCIATION

Date _____ Year _____ By _____
SIGNATURE AND OFFICIAL TITLE

PART 2 CLAIMANT'S STATEMENT

Date of Accident: _____ Did the accident take place in the course of employment?* ☐ Yes ☐ No

Briefly describe how the accident occurred: _____

_____

_____

_____

_____

Name of hospital if you were confined: _____

Dates of hospitalization: _____

Name of Attending Physician: _____

Physician's Address: _____
STREET CITY PROVINCE POSTAL CODE

Date of first treatment: _____

* If yes, please provide your accident report.

In what capacity or by what title do you claim this insurance money? _____

Are you over the age of 18?_____ If not, what is your date of birth? _____

Are you legally entitled to receive the whole of the monies payable under this policy, and to give the company a valid discharge therefor? _____

Are benefits to be released in a lump sum? ☐ Yes ☐ No

If No, an agent will call to discuss your options at your convenience.

PLEASE NOTE ADDITIONAL INFORMATION ON THE REVERSE SIDE OF THIS FORM

AUTHORIZATIONS AND DECLARATIONS

Protecting your Privacy
We take your privacy seriously. We keep all your personal information in a confidential file in our offices, or the offices of an organization we've authorized. The only person with access to the information are: people working at Canada Life and those we've authorized, who need the information to do their jobs and manage your claim, those whom you've given access, those authorized by law both within Canada and in any other jurisdiction where your personal information is held. For a copy of our Privacy Guideline see: **canadalife.com** or you can write to Canada Life's Chief Compliance Officer.

I have read and understand and agree with the contents of the section entitled "Protecting your Privacy" on this form.

I authorize Canada Life, any healthcare provider, the plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life or working with the deceased's plan administrator, within or outside Canada, to exchange personal information, when necessary to investigate and assess my claim, to administer the group benefits plan and to audit the assessment of the claim. I further authorize the use of my social insurance number for income tax reporting. I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

I have provided the information on this form in order to obtain payment of Group Life proceeds payable to me (in a personal capacity or on behalf of a beneficiary) and I hereby declare that I am legally entitled to receive all or a share of the proceeds payable under the Group Life Policy. I certify that by making payment to me, Canada Life has met its obligation to me. By signing below, I confirm that: I have read, understand and agree with the contents of this form and authorize Canada Life to collect, use, and disclose my personal information, all statements I have made about my claim are true and complete, my authorization is valid until I cancel it in writing, and a photocopy or electronic copy of this authorization is as valid as the original.

Print Name _____ Signature _____

Date _____ Social Insurance Number _____

INSTRUCTIONS

1. **ATTACH CERTIFICATE OF ATTENDING PHYSICIAN – DISMEMBERMENT OR LOSS (FORM NO. M4442).**
2. **ATTACH INSURED'S ENROLLMENT CARD AND ANY CHANGES, IF YOU RETAIN THIS RECORD.**
3. **ATTACH ACCIDENT REPORT (IE. POLICE REPORT, EMPLOYER'S ACCIDENT REPORT).**

Please return the fully completed form and supporting documents to:

The Canada Life Assurance Company
Group Life Benefits
60 Osborne St N
Winnipeg MB R3C 1V3

OR

Email: grouplifebenefits@canadalife.com
Fax: 204-946-8783

Email Communication - Important Note:
The internet is not a secure medium. If you have concerns about using email, you are encouraged to contact us by other means.

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