

GROUP LIFE BENEFIT CLAIM FOR ACCIDENTAL DISMEMBERMENT OR SPECIFIC LOSS

Instructions

- Plan Administrator: Please complete and sign Part 1
- Plan Member/Claimant: Please complete Part 2, as well as the Authorization and Declaration form on Page 2.
- Attach accident reports (i.e., police report, employer's accident report, etc.)
- Attach Certificate of Attending Physician – Dismemberment or Loss (M4442)

Submit the fully completed forms 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

Enrollment form and/or beneficiary designation is: Attached Held by Canada Life Member Self-Service Enrollment (MSSE)

PART 1: Plan Sponsor's or Administrator's Statement					
Name of Group Plan				Policy No.	
Plan Member's Name (first, last)				Phone No.	
Mailing Address			City	Province	Postal Code
Date of Birth (mm/dd/yyyy)	Date of Loss (mm/dd/yyyy)		Date of Employment (mm/dd/yyyy)	Last day worked (mm/dd/yyyy)	
Reason for leaving			Total amount of AD&D coverage		
Earnings as of last day worked			<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly <input type="checkbox"/> Other _____		
Completed by (please print)			Title		
Email address			Phone No.		
Signature				Date	
PART 2: Plan Member/Claimant's Statement					
Date of Accident (mm/dd/yyyy)			Did the accident occur at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Describe how the accident occurred:					
Were you admitted to a hospital <input type="checkbox"/> Yes <input type="checkbox"/> No			Hospital name		
Date admitted (mm/dd/yyyy)		Date discharged (mm/dd/yyyy)		<input type="checkbox"/> Still hospitalized	
Name of Attending Physician					
Physician's Address			City	Province	Postal Code
Please advise how you wish to receive these proceeds:					
<input type="checkbox"/> Cheque <input type="checkbox"/> EFT (Electronic Fund Transfer to Canadian bank account - please attach a personalized void cheque or an electronic bank form) <input type="checkbox"/> Please arrange for a financial advisor to visit and discuss my options. The best time to call me is _____					
Have you declared bankruptcy <input type="checkbox"/> Yes <input type="checkbox"/> No If so, enclose copies of the Trustee in Bankruptcy documents.					
Email Address (enter your email address if you would like Canada Life to communicate with you by secure email)					

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 _____