THE Great-West Life ASSURANCE COMPANY

PROOF OF DEATH (DEPENDENT LIFE INSURANCE)

STATEMENT OF EMPLOYER

- ☐ Healthcare Benefit Trust Policy #16277
- ☐ Joint Community Benefits Trust Policy #168689
- ☐ Joint Facilities Benefits Trust Policy #168688
- ☐ Joint Health Science Benefits Trust Policy #168687

Indicate which health and welfare trust was providing the deceased's Dependent Life coverage, by checking the applicable box above - For Reporting purposes only.

BENEFITS IDENTIFICATION NUMBER	FULL NAME OF EMPLOYEE		
	SURNAME	FIRST NAME	INITIALS

ADDRESS OF EMPLOYEE

FULL NAME OF DEPENDENT			DEPENDENT'S BIRTHDATE	DATE OF DEATH
SURNAME	FIRST NAME	INITIALS		

AMOUNT CLAIMED **$**

NAME OF EMPLOYER _____ DIV. # _____ UNION/EMPLOYEE GROUP _____

ADDRESS _____ TELEPHONE _____

DATED _____ SIGNED _____

NAME (please print) _____ TITLE _____

IMPORTANT REMINDER TO EMPLOYER - PLEASE ATTACH EMPLOYEE'S APPOINTMENT OF BENEFICIARY CARD. THIS CARD WILL BE RETURNED TO YOU UPON COMPLETION OF OUR ASSESSMENT OF THIS CLAIM. PLEASE KEEP A COPY FOR YOUR RECORDS.

MAIL ORIGINAL COPY AND DOCUMENTS TO:

BY MAIL
THE GREAT-WEST LIFE ASSURANCE COMPANY
PO BOX 6000
WINNIPEG MB R3C 3A5

OR

BY COURIER
THE GREAT-WEST LIFE ASSURANCE COMPANY
60 OSBORNE STREET N
WINNIPEG MB R3C 1V3

MAIL COPY OF THE FORM TO:

HEALTHCARE BENEFIT TRUST
SUITE 350
2889 E 12th AVENUE
VANCOUVER BC V5M 4T5

STATEMENT OF ATTENDING PHYSICIAN

I CERTIFY THAT	RESIDING AT
DIED ON	IMMEDIATE CAUSE
ILLNESS BEGAN ON	CONTRIBUTORY CAUSE
DATED	SIGNED M.D.
NAME (please print)	ADDRESS

NOTE - IF NO PHYSICIAN IN ATTENDANCE, A CERTIFICATE OF REGISTRATION OF DEATH OR A FUNERAL DIRECTOR'S STATEMENT OF DEATH SHOULD BE ATTACHED. (PHOTOCOPIES ARE ACCEPTABLE).

STATEMENT OF CLAIM FOR DEPENDENT'S LIFE INSURANCE

DECEASED'S FULL NAME			AGE
SURNAME	FIRST NAME	INITIALS	
CLAIMANT'S FULL NAME			RELATIONSHIP
SURNAME	FIRST NAME	INITIALS	
CLAIMANT'S SOCIAL INSURANCE NUMBER	ADDRESS		

Protecting Your Personal Information

At **The Great-West Life Assurance Company**, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life and the Trust indicated above. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or the Trust or persons authorized by Great-West Life or the Trust who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the group benefits plan. This includes investigating and assessing claims, and creating and maintaining records concerning our relationship. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

Authorizations and Declarations

I authorize Great-West Life, one of the Trusts indicated above, the Trustees of that Trust, their agents (including the Healthcare Benefit Trust where the Trust is not the Healthcare Benefit Trust, and Pacific Blue Cross), any healthcare provider, the Deceased's employer, my employer, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Great-West Life or working with my employer, to exchange personal information, when necessary to assess my claim and to administer the group benefits plan.

I have provided the information on this form in order to obtain payment of any Dependent Life proceeds payable to me and I hereby declare that I am legally entitled to receive the proceeds payable under the Group Policy. I certify that by making payment to me, Great-West Life and the Trust have met their obligation to me. I further declare that the answers given by me are, to the best of my knowledge and belief, true and full, and I have withheld no material facts from Great-West Life or the Trust.

I confirm that a photocopy or electronic copy of this authorization is as valid as the original.

Claimant Signature _____ Date _____

Claimant Name (please print) _____ Witness Signature _____

Clear