

**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 employee'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	EMAIL ADDRESS		
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:	MAIL COPY OF THE FORM TO:
BY MAIL THE CANADA LIFE ASSURANCE COMPANY PO BOX 6000 WINNIPEG MB R3C 3A5	OR BY COURIER THE CANADA LIFE ASSURANCE COMPANY 60 OSBORNE STREET N WINNIPEG MB R3C 1V3
	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
CLAIMANT'S FULL NAME	RELATIONSHIP
SURNAME	FIRST NAME
CLAIMANT'S SOCIAL INSURANCE NUMBER	ADDRESS

Protecting Your Privacy

At The Canada 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 Canada Life or the offices of an organization authorized by Canada 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 Canada Life. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or the Trust or persons authorized by Canada 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 Canada Life's Chief Compliance Officer or refer to canadalife.com.

Authorizations and Declarations

I authorize Canada 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, my employer, 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 my employer, to exchange personal information, when necessary to assess my claim and to administer the group benefits plan. 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 any Dependent 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 Policy. I certify that by making payment to me, Canada 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 Canada 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 _____