PROOF OF DEATH
(GROUP LIFE AND ACCIDENTAL DEATH INSURANCE)
STATEMENT OF EMPLOYER

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

HEALTHCARE BENEFIT TRUST — BENEFIT FROM EXPERIENCE

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

BENEFITS IDENTIFICATION NUMBER	NAME OF DECEASED SURNAME / FIRST NAME / INITIALS
ADDRESS OF DECEASED	EMAIL ADDRESS

DATE OF BIRTH	DATE OF DEATH	DATE EMPLOYED	DATE LAST WORKED	OCCUPATION AT DEATH	CAUSE OF DEATH IF KNOWN

IMMEDIATELY PRIOR TO DATE OF DEATH, THE DECEASED WAS:
☐ AT WORK ☐ ON SICK LEAVE ☐ ON L.T.D. ☐ OTHER (SPECIFY) _____

AMOUNT OF GROUP LIFE INSURANCE CLAIMED $

UNION / EMPLOYEE GROUP

COMPLETE ONLY FOR ACCIDENTAL DEATH BENEFIT

AMOUNT OF ACCIDENT INSURANCE CLAIMED $ _____

WHERE DID ACCIDENT OCCUR ☐ HOME ☐ WORK ☐ ELSEWHERE

DATE OF ACCIDENT

CIRCUMSTANCES

NAME OF EMPLOYER _____ DIV. # _____

ADDRESS _____ TELEPHONE _____

DATED _____ SIGNED _____

NAME (please print) _____ TITLE _____

IMPORTANT REMINDER TO EMPLOYER: PLEASE ATTACH ALL OF THE DECEASED'S APPOINTMENT OF BENEFICIARY CARDS. **PLEASE KEEP A COPY FOR YOUR RECORDS.**

MAIL ORIGINAL COPY AND DOCUMENTS 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

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 CLAIMANT

NOTE - WHEN PROCEEDS PAYABLE TO THE INSURED'S ESTATE, THE CLAIMANT'S STATEMENT SHOULD BE COMPLETED BY THE ESTATE'S LEGAL REPRESENTATIVE.

NAME OF DECEASED

SURNAME / FIRST NAME / INITIALS

CLAIMANT'S FULL NAME SURNAME / FIRST NAME / INITIALS	AGE	TELEPHONE
CLAIMANT'S SOCIAL INSURANCE NUMBER	ADDRESS	

Supporting Documents - The **claimant** should submit the following documents to the Deceased's Employer along with the completed claim form.

Proof of Death - Death Certificate, Funeral Director's Statement of Death, or completion of the Statement of Attending Physician with original signature on this claim form. (Photocopies are accepted but original is required if death occurred outside of North America)

For Accidental Death claims:

- Police Report or workplace accident report, and Coroner's Report or Autopsy Report

When proceeds are payable to the Insured's estate and exceed $50,000:

- Notarized Copy of the Will (if the Insured left a Will) and Probate;
- Certificate of Appointment of Estate Trustee, or
- Letter of Administration, as applicable.

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 www.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, the Deceased's 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 the Deceased's 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 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 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 _____

Clear