



Application for Group Critical Illness Benefits Employer's Statement

Important:

The completed Employer's and Employee's Statements are required before claim assessment can commence. **These forms should be submitted to Canada Life within the established criteria.** Canada Life's Privacy Guidelines and applicable law allow employees to have access to personal information in their files. Please be aware that any information you provide us in connection with these services may be subject to access by the employee.

Instructions:

Please provide a copy of the enrolment form to validate Critical Illness enrolment. If an enrolment form is not available, print screen will be accepted as confirmation. Please ensure that the print screen indicates Critical Illness Insurance for themselves and for any/all dependents.

A. EMPLOYER IDENTIFICATION

Name	Plan Number	Division Number (if applicable)	Class (if applicable)
Address: Street & Number	P.O. Box	City	Province
Telephone Number	Fax Number		
Address: Street & Number		P.O. Box	Postal code

B. EMPLOYEE IDENTIFICATION

Name: First	Initial	Last	Employee I.D. or Cert. Number	Employee or Dependent Division Number	Date of Birth (MM/DD/YY)
Address: Street & Number		P.O. Box	City	Province	Postal Code

C. EMPLOYMENT INFORMATION

Date of Employee's Employment (MM/DD/YY)	Effective Date of C.I. for Employee (MM/DD/YY)
Amount of C.I. for Employee	Effective Date of C.I. for Dependent(s) (MM/DD/YY)
Amount of C.I. for Dependent(s)	

DECLARATION

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Authorized Signature: _____ **Date:** _____

Name (please print): _____ **Title:** _____

Phone: _____ **Fax:** _____ **E-Mail:** _____

Submit to: The Canada Life Assurance Company
Creditor Insurance - Critical Illness Unit
330 University Avenue, S3
Toronto ON M5G 1R8
GroupCIClaims@canadalife.com
Toll Free 1.866.907.2395
Fax 416.552.6557