GROUP PORTABLE ACCIDENTAL DISMEMBERMENT OR SPECIFIC LOSS CLAIM

PART 1 STATEMENT

Name of Claimant: _____

☐ Member ☐ Spouse ☐ Child

Claimant Phone No.: _____ Address: _____

Group Policy No.: 177914 Certificate No.: _____

Total amount of insurance coverage: $ _____ Date of Birth: _____
(yyyy/mm/dd)

Amount of Accidental Dismemberment or Loss Benefit: $ _____

In what capacity or by what title do you claim this insurance money? _____

Are you over the age of 18? _____ If not, what is your date of birth? _____

Are you legally entitled to receive the whole of the monies payable under this policy, and to give the company a valid discharge therefor? _____

Please advise how you wish to receive these proceeds

☐ I have chosen a lump sum payment of these proceeds, or.

☐ Please arrange for a financial advisore to visit and discuss my options. The best time to call me is _____

PLEASE NOTE ADDITIONAL INFORMATION ON THE REVERSE SIDE OF THIS FORM

PART 2 ACCIDENT DETAILS

Date of Accident: _____ Did the accident take place in the course of employment?* ☐ Yes ☐ No

Briefly describe how the accident occurred:

_____

_____

_____

_____

Name of hospital if you were confined: _____

Dates of hospitalization: _____

Name of Attending Physician: _____

Physician's Address: _____
STREET CITY PROVINCE POSTAL CODE

Date of first treatment: _____

* If yes, please provide your accident report.

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 _____

INSTRUCTIONS

1. **ATTACH INSURED'S BENEFICIARY DESIGNATION FORM, IF YOU HAVE THIS RECORD.**
2. **ATTACH CERTIFICATE OF ATTENDING PHYSICIAN (FORMS ATTACHED TO THIS CLAIM FORM)**
3. **ATTACH ACCIDENT REPORT (IE. POLICE REPORT, EMPLOYER'S ACCIDENT REPORT).**

Please return the fully completed form 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

Email Communication - Important Note:
The internet is not a secure medium. If you have concerns about using email, you are encouraged to contact us by other means.

GROUP PORTABLE ACCIDENTAL OR LOSS BENEFITS CERTIFICATE OF ATTENDING PHYSICIAN

Patient's Name: _____

Patient's Address: _____

Group Policy Number: 177914 Group Plan Name: Canada Life Insurance Company of Canada

1. (a) When did the accident happen? Month _____ Day _____ Year _____

   (b) Briefly describe details of the accident. _____

2. (a) Date of first attendance for present injury. Month _____ Day _____ Year _____

   (b) Date of most recent treatment. Month _____ Day _____ Year _____

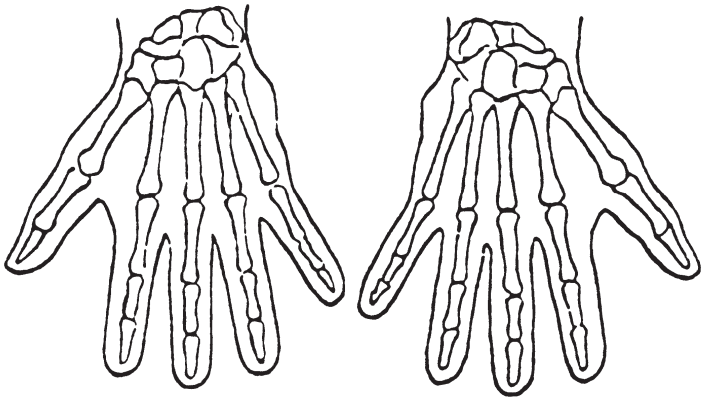
DISMEMBERMENT

3. (a) If the accident caused the loss of hand, foot, leg, arm, fingers, toes, please indicate the specific joint level of the amputation on the diagram below.

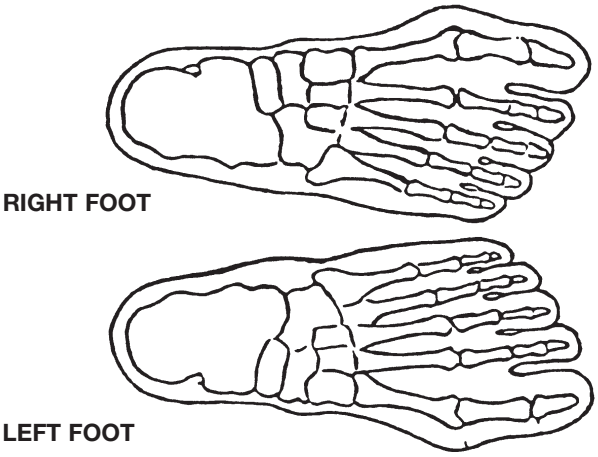
   ☐ Hand ☐ Foot ☐ Leg ☐ Arm ☐ Fingers ☐ Toes

   (b) Date of amputation. Month _____ Day_____ Year _____

   (c) Please include surgery report and hospital admittance and discharge summary.

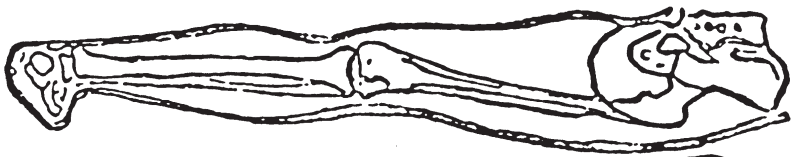


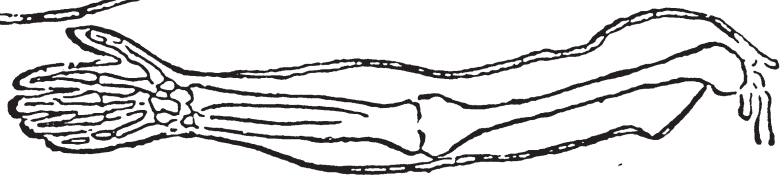
LEFT HAND RIGHT HAND



RIGHT FOOT

LEFT FOOT





INDICATE WHETHER RIGHT OR LEFT

4. (a) If the accident caused total and irrecoverable loss of sight, hearing or speech, please indicate which:

☐ Sight ☐ Hearing ☐ Speech

(b) Date on which loss occured. Month _____ Day _____ Year _____

(c) Is there any possibility of improvement to the injured area? ☐ Yes ☐ No

LOSS OF VISION

(a) If known to you, please advise the vision in each eye prior to the accident.

_____

(b) What is the best corrected vision in the affected eye(s), if any?

_____

(c) Please include visual acuity results and Opthalmologist report.

LOSS OF HEARING

(a) Is there any indication that hearing was abnormal prior to accident?

_____

(b) Level of hearing at date of loss.

_____

(c) Please include Audiologist report and hearing test.

LOSS OF SPEECH

(a) If known to you please advise if the insured was able to speak intelligibly prior to accident.

_____

(b) Is insured's speech intelligible at the present time?

_____

(c) Please include Speech Therapy assessment.

LOSS OF USE

5. (a) If the accident caused loss of use of leg, arm, or hand, please advise which.

☐ Leg ☐ Arm ☐ Hand

(b) Is there any indication that the injured limb was unable to function normally prior to accident? ☐ Yes ☐ No

(c) Please indicate what functions, if any, the injured limb is able to perform.

_____

(d) Is there any possibility of improvement to the injured area? ☐ Yes ☐ No

(e) Please include: Hospital admittance and discharge summary, surgery report (if relevant), Range of Motion test results and Physiotherapist / Occupational Therapist reports, consultation and progress reports, Neurologic exam (paraplegia / quadriplegia).

6. (a) Was the injury described solely responsible for the loss? ☐ Yes ☐ No

(b) If not, give particulars of any contributing cause or causes.

_____

_____

_____

Print Name _____ Specialty _____ Telephone Number: _____

Date _____ Signed _____ M.D.

Address _____

Street City Province Postal Code

Clear