GROUP PORTABLE LIFE BENEFITS CLAIMANT STATEMENT

INSTRUCTIONS ON REVERSE

Deceased Information

Name of deceased ☐ Plan member ☐ Dependent		
Date of birth	Date of death	Cause of death
Address		
Plan name **CANADA LIFE INSURANCE COMPANY OF CANADA**	Group Life policy number **177914**	Certificate Number

Benefit Claimed ☐ Life $ _____

☐ Accidental Death $ _____

When proceeds are payable to the estate, please include social insurance number _____

Claimant Information

Claimant's name	Relationship to the deceased
Address	
Phone number	Claimant's date of birth

Social insurance number, security number or taxpayer account number _____

Claimant's basis of claim (check one)

☐ Named beneficiary ☐ Beneficiary's guardian/legal tutor or curator ☐ Estate's legal representative ☐ Trustee

☐ Other, please specify _____

The life insurance proceeds are non-taxable. Please advise how you wish to receive these proceeds:

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

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

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.

Authorizations and Declarations

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.

_____ _____

Claimant signature Date

_____ _____

Claimant's name (please print) Witness signature

GROUP PORTABLE LIFE BENEFITS CLAIMANT STATEMENT

INSTRUCTIONS

Who should complete the *Group Life Claimant Statement*

Proceeds payable to:					
Adult beneficiary	Beneficiary who is a minor or who lacks legal capacity, located in Quebec	Beneficiary who is a minor or who lacks legal capacity, located outside Quebec	Claimant unable to handle financial affairs	Estate	Estate in Quebec with no will
1 or 2	2 or 3 or 4	2 or 4	5	6	7
1. Beneficiary 2. Trustee (copies of trust documents required) 3. Legal tutor or curator (copies of judgment required) 4. Court appointed guardian of the beneficiary's property (copies of court order required)			5. Claimant's legal representative (copies of judgment required) 6. Estate's legal representative 7. Legal heirs		

Documents Required for the *Group Life Claimant Statement* (copies are acceptable unless indicated)

Portable Life	Portable Life exceeding $100,000 in Quebec	Portable Life outside of North America	Accidental Death	Insurance proceeds payable to the estate exceeding $100,000 in Quebec	Insurance proceeds payable to the estate exceeding $100,000 outside Quebec
2	9	10	1 or 2 and 3, 4	5, 6 and 7 or 8	2 and 9
1. Death certificate or funeral director's statement of death 2. Attending Physician's Certificate (M63) 3. Police report or workplace accident report 4. Medical Examiner's Report, Coroner's Report or Autopsy Report 5. Act of Death (long form) issued by the Quebec Registrar of Civil Status			6. Will search certificate from the Chambre des Notaires and The Barreau du Quebec) 7. Notarial will or holograph will with judgment/minutes 8. Declaration of legal heirs if there is no will 9. Notarized will and probate or certificate of appointment of Estate Trustee or Letter of administration 10. Original death certificate or certified true copy of the death certificate by a notary public		

***Canada Life reserves the right to request additional information**

Please return the 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 LIFE BENEFITS
ATTENDING PHYSICIAN'S CERTIFICATE OF DEATH

I hereby certify that _____

of _____

died on the _____ day of _____ , 20 _____, from

(Chief or Primary cause) _____

(Contributing or secondary cause) _____

When was the illness diagnosed? _____

When in your opinion did the last illness become severe enough to prevent them from working?

_____

_____

_____

_____

_____

_____

_____

What was the manner of death? ☐ Natural ☐ Accidental ☐ Suicide ☐ Homicide ☐ Undetermined

Did the deceased smoke? ☐ Yes ☐ No If yes, for how long? _____

Dated at _____ this _____ day of _____ 20 _____

This form should be completed in full by the Attending Physician.

Dr. _____
(Doctor's signature)

_____
(Doctor's name - please print)

_____
(Address)

_____
(Telephone)

Clear