Manulife Financial

Life Claim

Please see instructions on page 2 for completing this form.

Instructions for completion & requirements

○ PLAN MEMBER LIFE CLAIM *(please print all answers)*

Complete page 1 & 2 of this form

- Plan administrator complete and sign section 1,
- Claimant complete and sign section 2.

Please check for the following requirements:

Proceeds UNDER $300,000

○ Original or notarized copy of Funeral Director's Statement of Death, and newspaper death report or obituary notice (if available)

OR

○ Attending Physician's Statement (page 7 of this form)

Proceeds $300,000 and OVER

○ Original or notarized copy of Provincial Death Certificate

OR

○ Attending Physician's Statement (page 7 of this form)

Accidental Death

○ Attending Physician's or Coroner's Statement (page 9 of this form)

Plan sponsor administered group ***(please complete section for plan sponsor administered groups)***

○ ORIGINAL of the Plan Member Enrolment form

○ DEPENDENT LIFE CLAIM *(please print all answers)*

Complete page 3 & 4 of this form

- Plan administrator complete and sign section 1,
- Plan member complete and sign section 2.

Please check for the following requirements:

Proceeds UNDER $300,000

○ Original or notarized copy of Funeral Director's Statement of Death, and newspaper death report or obituary notice (if available)

OR

○ Original or notarized copy of Provincial Death Certificate

Proceeds $300,000 and OVER

○ Original or notarized copy of Provincial Death Certificate

OR

○ Attending Physician's Statement (page 7 of this form)

Accidental Death (if applicable)

○ Attending Physician's or Coroner's Statement (page 9 of this form)

Plan sponsor administered group ***(please complete section for plan sponsor administered groups)***

○ COPY of the Plan Member Enrolment form

Miscellaneous requirements

Payments to minor beneficiary

○ ORIGINAL or NOTARIZED copy of Court appointment of Guardianship of the Estate of the Minor

Payments to estate

○ ORIGINAL or NOTARIZED copy of the Probated Will or Letters of Administration for proceeds $50,000 and over.

Beneficiary has died before the plan member

○ ORIGINAL or NOTARIZED/CERTIFIED copyof deceased Beneficiary's Proof of Death

If you live outside Quebec:

Manulife Financial
Waterloo Group Life Claims Office
PO BOX 800
KITCHENER ON N2G 4Y5

Tel: 1-877-481-9169
(519) 747-7000
Fax: (519) 579-3680

If you live in Quebec:

Manulife Financial
Montreal Group Life Claims Office
2000 MANSFIELD ST, 8TH FLOOR
MONTREAL QC H3A 3N8

Tel: 1-866-236-6313
(514) 288-6268
Fax: (514) 286-6738

Manulife Financial

Group Benefits
Plan Member Claim
Life and Accidental Death (if applicable)

For dependent death claim use pages 5 & 6. Please print clearly.

1 Plan administrator's statement for death of plan member

Plan number(s)	Account/Division number	Union local	Certificate number

Plan sponsor's name	Employer's name (if different from plan sponsor)

Deceased plan member's name (last, first, middle initial)	Date of birth (dd/mmm/yyyy)

Date of employment (dd/mmm/yyyy)	Job title

Beneficiary's name (last, first, middle initial)	Relationship

Amount of **basic** insurance (Life & Accidental Death)
Basic $ _____ Accidental Death $ _____

Amount of **optional** insurance (Optional Life & Optional Accidental Death)
Optional Life $ _____ Optional Accidental Death $ _____

Date last worked (dd/mmm/yyyy)	Current salary $ _____	◯ Annually ◯ Monthly ◯ Semi-monthly ◯ Bi-weekly ◯ Weekly ◯ Hourly

Regular number of hrs. worked/week	Salary effective date (dd/mmm/yyyy)	Date of death (dd/mmm/yyyy)	Date of termination (if applicable) (dd/mmm/yyyy)

If death occurred after date last actively at work, please indicate status:

◯ Retired ◯ Disabled ◯ Temporary layoff ◯ Leave of absence

If plan member was disabled prior to death, was any claim for disability benefits filed during this period?

◯ Yes ◯ No If "Yes", please provide claim number and name of carrier.

Claim number	Name of carrier

Was this death accidental? ◯ Yes ◯ No

If "Yes", please have the Attending Physician's or Coroner's Statement (page 7) completed and submit with this claim.

Date of accident (dd/mmm/yyyy)

Did the accident occur while plan member was working?

◯ Yes ◯ No If "Yes", please give location and address of accident.

Location of accident	Address of accident

For Optional Life only - Was plan member insured at non-smoker rates?

◯ Yes ◯ No If "Yes", attach copy of declaration.

For plan sponsor administered groups only.

*Please submit **ORIGINAL** enrolment form for this plan member.*

Plan member insurance class (if applicable)	Most recent effective date of plan member's coverage (dd/mmm/yyyy)	Original effective date of plan member's coverage (dd/mmm/yyyy)	Date to which premiums were paid (dd/mmm/yyyy)

Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Authorized signature	Date signed (dd/mmm/yyyy)	Area code and phone number
x		( )

Mailing address (number, street)	City	Province	Postal code
			—

The information in this statement will become part of a group life and health benefits file which might be accessible by the other third parties to whom access has been granted or those authorized by law.

2 Claimant's statement for death of a plan member

Claimant's name (last, first, middle initial)

Policy numbers of other Manulife Financial policies for which a claim is being made

Claimant's mailing address (number, street)	City	Province	Postal code
			—

Relationship to deceased plan member	Claimant's date of birth (dd/mmm/yyyy)	Claimant's Social Insurance Number
		— —

Cause of death

IF DEATH WAS ACCIDENTAL, please answer the following questions. Use a separate sheet of paper if required. If not accidental, please read and sign below.

Date of accident (dd/mmm/yyyy)	Time of accident
	◯ A.M. ◯ P.M.

Fully describe the accident; where was the deceased and what was he/she doing at the time of the accident?

Please provide the names and addresses of any witnesses to the accident.

Name(s)	Address(es)

Did the deceased ever suffer from fainting spells or any bodily or mental disorder?

◯ Yes ◯ No If "Yes", please explain fully.

Claimant's certification and authorization for all death claims

I certify that the statements provided by me are true and complete to the best of my knowledge and belief.
I, the undersigned, hereby make claim for the group life insurance on the deceased,

_____

(name of deceased)

I understand Manulife Financial may investigate this claim. I authorize any employer, physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medical or medically-related facility, insurance company, group plan administrator, or any other corporation, organization, institution, association or person, Police authorities or coroner, to release and exchange with Manulife Financial any medical, or any other information or records including Police investigation, autopsy or coroner's inquest reports that may be requested by Manulife Financial to process this claim.
I authorize the use of my Social Insurance Number for the purpose of tax reporting.
I agree that a photocopy of this authorization shall be as valid as the original.

Claimant's signature

Claimant's signature	Date signed (dd/mmm/yyyy)
x	

At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to this information will be limited to:
- our employees and service representatives in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to this file, and, if necessary, correct any inaccurate information.

Manulife Financial

Group Benefits
Dependent Claim
Life and Accidental Death (if applicable)

For plan member death claim use pages 3 & 4. Please print clearly.

1 Plan administrator's statement for death of dependent - plan member details

Plan number(s)	Account/Division number	Union local	Certificate number

Plan sponsor's name	Employer's name (if different from plan sponsor)

Plan member's name (last, first, middle initial)	Date of birth (dd/mmm/yyyy)

Plan member's mailing address (number, street)	City	Province	Postal code
			—

Date of employment (dd/mmm/yyyy)	Job title

Amount of **basic** insurance (Life & Accidental Death)	Amount of **optional** insurance (Optional Life & Optional Accidental Death)
Basic $ _____ Accidental Death $ _____	Optional Life $ _____ Optional Accidental Death $ _____

Date last worked (dd/mmm/yyyy)	Current salary	
	$ _____	◯ Annually ◯ Semi-monthly ◯ Weekly ◯ Monthly ◯ Bi-weekly ◯ Hourly

Regular number of hrs. worked/week	Salary effective date (dd/mmm/yyyy)	Date of death (dd/mmm/yyyy)	Date of termination (if applicable) (dd/mmm/yyyy)

If death occurred after date last actively at work, please indicate status:

◯ Retired ◯ Disabled ◯ Temporary layoff ◯ Leave of absence

If plan member was disabled, was any claim for disability benefits filed during this period?

◯ Yes ◯ No If "Yes", please provide claim number and name of carrier.

Claim number	Name of carrier

Deceased dependent's name (last, first, middle initial)	Relationship to plan member

Was this death accidental? ◯ Yes ◯ No

If "Yes", please have the Attending Physician's or Coroner's Statement (page 9) completed and submit with this claim.

Date of accident (dd/mmm/yyyy)

Did the accident occur while dependent was working?

◯ Yes ◯ No If "Yes", please give location and address of accident.

Location of accident	Address of accident

For Optional Life only - If claim is for spouse, was dependent spouse insured at non-smoker rates?

◯ Yes ◯ No If "Yes", attach copy of declaration.

For plan sponsor administered groups only.
*Please submit **COPY** enrolment form for this plan member.*

Plan member insurance class (if applicable)	Most recent effective date of plan member's coverage (dd/mmm/yyyy)	Original effective date of dependent's coverage (dd/mmm/yyyy)	Date to which premiums were paid (dd/mmm/yyyy)

Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Authorized signature	Date signed (dd/mmm/yyyy)	Area code and phone number
x		( )

Mailing address (number, street)	City	Province	Postal code
			—

The information in this statement will become part of a group life and health benefits file which might be accessible by the Plan Member or third parties to whom access has been granted or those authorized by law.

2 Plan member's statement for death of a dependent

Deceased dependent's address (number, street)	City	Province	Postal code
			—

Deceased's date of birth (dd/mmm/yyyy)	Deceased's marital status	If deceased was a dependent child and attending school, name institution
	◯ Married ◯ Single	

Cause of death	Date of death (dd/mmm/yyyy)

If deceased died in hospital, please give date admitted ▶ (dd/mmm/yyyy)

At time of death, was the dependent employed? ◯ Yes ◯ No If "Yes," indicate number of hours worked — No. of hours per week

Was he/she dependent on you for support? ◯ Yes ◯ No

Was the dependent confined to a hospital when coverage became effective? ◯ Yes ◯ No

If "Yes," indicate date discharged (dd/mmm/yyyy)

Please provide the following information regarding YOURSELF.

Your name (last, first, middle initial)	
Your Social Insurance Number — —	Relationship to deceased

Plan member's certification and authorization for all death claims

I certify that the statements provided by me are true and complete to the best of my knowledge and belief.
I, the undersigned, hereby make claim for the group life insurance on the deceased,

_____
(name of deceased)

I understand Manulife Financial may investigate this claim. I authorize any employer, physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medical or medically-related facility, insurance company, group plan administrator, or any other corporation, organization, institution, association or person, Police authorities or coroner, to release and exchange with Manulife Financial any medical, or any other information or records including Police investigation, autopsy or coroner's inquest reports that may be requested by Manulife Financial to process this claim.
I authorize the use of my Social Insurance Number for the purpose of tax reporting and if my social insurance number is used as my certificate number, I authorize it's use for the identification and administration of my group benefits.
I agree that a photocopy of this authorization shall be as valid as the original.

Plan member's signature

Plan member's signature	Date signed (dd/mmm/yyyy)
x	

At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to this information will be limited to:
- our employees and service representatives in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to this file, and, if necessary, correct any inaccurate information.

Manulife Financial

Group Benefits
Attending Physician's Report

If there is a charge for the completion of this form, payment is the responsibility of the claimant. Please print clearly.

Completed reports should be returned to:

Plan number(s)	Account/Division number	Union local	Certificate number

Plan administrator's name (last, first, middle initial)

Plan administrator's mailing address (number, street)	City	Province	Postal code
			—

The Medical Certification follows the recommendation of the World Health Assembly made in Geneva on July 24, 1948. It has been accepted in Canada and the United States. In the interest of accurate vital statistics, please conform to the International List of Causes of Death. When complete, please return this form to the plan administrator at the address shown above.

Physician's report

Deceased's name (last, first, middle initial)	Place of death	Date of death (dd/mmm/yyyy)

If death occurred in an institution or hospital, please give name	Age at death

Residence address at death (number, street)	City	Province	Postal code
			—

Cause of death

Enter only one cause for each of a, b and c.

Disease and condition directly leading to death: (This does not mean the mode of dying such as heart failure, asthenia, etc. It means the disease, injury or complication which caused the death).

(a)	**Interval between onset and death** (a)

Antecedent causes. (Morbid conditions, if any, giving rise to the above cause (a) stating underlying causes last).

Due to (b)	(b)
Due to (c)	(c)

To your knowledge, did the deceased ever smoke? ◯ Yes ◯ No ◯ I don't know

If "Yes", how many years? Number of years

Date of first attendance in last illness (dd/mmm/yyyy)

Date of last attendance in last illness (dd/mmm/yyyy)

If death was due to accident, suicide or homicide, specify which and describe briefly.

Was an inquest held? ◯ Yes ◯ No

Was an autopsy performed? ◯ Yes ◯ No

If "Yes," to either of the above, by whom and what findings?

Have you treated or advised the deceased during the last five years, prior to last illness? ◯ Yes ◯ No

Did the deceased, to your knowledge, receive treatment during the last five years from any other physician, or in any hospital or institution? ◯ Yes ◯ No

If "Yes," to either of the above, please provide the following information.

Name	Address	Nature of illness/injury	Approximate dates
			(dd/mmm/yyyy)
			(dd/mmm/yyyy)

Please complete page 8 of this form.

Attending physician's personal information

Attending physician's full name		Degree or qualification	
Address (number, street)	City	Province	Postal code —
Area code and phone number ( )			

Attending physician's signature

Attending physician's signature	Date signed (dd/mmm/yyyy)
x	

The information in this statement will become part of a group life and health benefits file which might be accessible by third parties to whom access has been granted or those authorized by law.

Manulife Financial

Group Benefits
Attending Physician's or Coroner's Statement for Accidental Death

If there is a charge for the completion of this form, payment is the responsibility of the claimant. Please print clearly.

Completed reports should be returned to:

Plan number(s)	Account/Division number	Union local	Certificate number

Plan administrator's name (last, first, middle initial)

Plan administrator's mailing address (number, street)	City	Province	Postal code
			—

Attending physician's or coroner's statement for accidental death

Deceased's name (last, first, middle initial)	Date of injury (dd/mmm/yyyy)	Date of death (dd/mmm/yyyy)

What was the precise nature and extent of the injury?

What was the primary or immediate cause of death?

Was the deceased ever treated for a similar condition?

◯ Yes ◯ No If "Yes," where and by whom?

Were there any contributing or remote causes of death?

◯ Yes ◯ No If "Yes," what were they?

Was the injury, described above, by itself and independent of all other causes, sufficient to cause death?

◯ Yes ◯ No If "No," please explain fully.

At the time of the injury, was the deceased under the influence of alcohol or narcotic drugs?

◯ Yes ◯ No If "Yes," please show blood alcohol content and type of drug.

Blood alcohol content	Type of drug

Was an autopsy performed? ◯ Yes ◯ No

Please complete page 10 of this form.

Attending physician's or coroner's personal information

Attending physician's or coroner's full name		Degree or qualification	
Address (number, street)	City	Province	Postal code —
Area code and phone number ( )			

Attending physician's or coroner's signature

Attending physician's or coroner's signature	Date signed (dd/mmm/yyyy)
x	

The information in this statement will become part of a group life and health benefits file which might be accessible by third parties to whom access has been granted or those authorized by law.