# Life Claim

Please see instructions on page 2 for completing this form.

### Instructions for completion & requirements

○ PLAN MEMBER LIFE CLAIM (please print all answers)	$\bigcirc$ DEPENDENT LIFE CLAIM (please print all answers)
Complete <u>page 1 &amp; 2</u> of this form	Complete <u>page 3 &amp; 4</u> of this form
<ul> <li>Plan administrator complete and sign section 1,</li> </ul>	<ul> <li>Plan administrator complete and sign section 1,</li> </ul>
<ul> <li>Claimant complete and sign section 2.</li> </ul>	<ul> <li>Plan member complete and sign section 2.</li> </ul>
Please check for the following requirements:	Please check for the following requirements:
Proceeds <u>UNDER</u> \$300,000	Proceeds <u>UNDER</u> \$300,000
<ul> <li>Original or notarized copy of Funeral Director's Statement of Death, and newspaper death report or obituary notice (if available)</li> </ul>	<ul> <li>Original or notarized copy of Funeral Director's Statement of Death, and newspaper death report or obituary notice (if available)</li> </ul>
OR	OR
$\bigcirc$ Attending Physician's Statement (page 7 of this form)	$\bigcirc$ Original or notarized copy of Provincial Death Certificate
Proceeds \$300,000 and <u>OVER</u>	Proceeds \$300,000 and <u>OVER</u>
$\bigcirc$ Original or notarized copy of Provincial Death Certificate	$\bigcirc$ Original or notarized copy of Provincial Death Certificate
OR	OR
$\bigcirc$ Attending Physician's Statement (page 7 of this form)	$\bigcirc$ Attending Physician's Statement (page 7 of this form)
Accidental Death	Accidental Death (if applicable)
<ul> <li>Attending Physician's or Coroner's Statement (page 9 of this form)</li> </ul>	<ul> <li>Attending Physician's or Coroner's Statement (page 9 of this form)</li> </ul>
Plan sponsor administered group (please complete section for plan sponsor administered groups)	Plan sponsor administered group (please complete section for plan sponsor administered groups)
$\bigcirc$ ORIGINAL of the Plan Member Enrolment form	$\bigcirc$ COPY of the Plan Member Enrolment form

### Miscellaneous requirements

### Payments to minor beneficiary

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

#### Payments to estate

O 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

O 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

### 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)		Accol	Account/Division number		Unior	Tiocai	Certificate number			
Plan sponsor's name					Employer's r	name (if dif	ferent f	rom plan s	sponsor)	
Deceased plan member's name (last, first, middle initial)				)	Date of birth (dd/mmm/yyyy)					
Date of employm	ent (dd/mmm	/уууу)	Job title							
Beneficiary's nam	ne (last, first, r	middle initia	al)			Relatio	onship			
Amount of <b>basic</b> Basic <b>\$</b>	Accie	dental 🕁	ental Death)	Optio	unt of <b>optional</b> <sup>onal</sup> \$	(	Intiona	1		Accidental Dea
Date last worked	Deat (dd/mmm/yyy	un •	Current salary		•		ally (	ž	monthly	O Weekly
Regular number worked/week	of hrs. Sala	ary effective	\$ e date (dd/mmr	n/yyyy)	Date of death	(dd/mmm/	,		of terminat	Hourly ion ld/mmm/yyyy)
If death occur	red after d	late last	actively at y	work n	ease indica	te statu	s.			
Retired	$\sim$	sabled		emporary		~	e of abs	ence		
f plan membe	er was disa	abled pri		e claim	ny claim for number and		-		d during	g this perio
f plan membe Yes I Claim number Was this deat f "Yes", pleas	er was disa No If "Y	abled pri Yes", ple tal?	ase provide Name of carr ) Yes N ing Physicia	e claim <sup>ier</sup> lo an's or (	number and		of car	rier.		g this perio
If plan member Yes I Claim number Was this deat If "Yes", pleas Statement (pa Did the accide	er was disa No If "Y th accident se have the age 7) com	abled pri Yes", ple tal? C e Attendi npleted a while pla	ase provide Name of carr Yes N ing Physicia and submit v n member v	e claim <sup>ier</sup> an's or ( with this was wo	number and Coroner's s claim. rking?	d name of a	ccident	rier.		g this peric
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### For plan sponsor administered groups only

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

Declaration

#### 2 Claimant's statement for death of a plan member

Claimant's name	(last,	first,	middle	initial)
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Date of accident (dd/mmm/yyyy)

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	Claimanť	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.

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

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

PI

Time of accident

○ A.M. ○ P.M.

Name(s)		Address(es)
Did the deceased e	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

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

Date signed (dd/mmm/yyyy)

### 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)	1.000	Account/Division number		Union local Cer			ertificate number			
Plan sponsor's name				Employer	's name	e (if diffe	erent fro	m plan s	sponsor)	
Plan member's name (	(last, first, middle ii	nitial)					Date	of birth (	(dd/mmm/	′уууу)
Plan member's mailing	g address (number	, street)	City			f	Province		Postal co	ode
Date of employment (d	ld/mmm/yyyy)	Job title								
Amount of <b>basic</b> insura Basic \$	ance (Life & Accid Accidental _ Death \$_	ental Death)	Amo Opti Life	unt of <b>optio</b> <sup>onal</sup> \$	nal insu	0	Optiona ptional ccidenta			Accidental Deat
Date last worked (dd/m	nmm/yyyy)	Current salar	y			Annual Monthl		) Semi- ) Bi-we	monthly ekly	O Weekly O Hourly
Regular number of hrs worked/week	. Salary effectiv	e date (dd/mm	m/yyyy)	Date of dea	ath (dd/	mmm/y	ууу)		of terminat licable) (d	tion Id/mmm/yyyy)
			·							
Yes No	If "Yes", ple	ease provide Name of car	e claim	-		ame o	f carrie	er.		
Yes No	If "Yes", ple	ease provide Name of car	e claim	-		ame o	f carrie	er.	member	
Yes No Claim number Deceased dependent's Was this death ac f "Yes", please ha	If "Yes", ple	Are provide Name of car middle initial)	e claim rier No an's or	number a	and na	ame o Relat	f carrie	er. to plan i	member	
Claim number Deceased dependent's Was this death ac If "Yes", please ha Statement (page S Did the accident o	If "Yes", ple s name (last, first, f ccidental? ( ave the Attend 9) completed a poccur while dep	ease provide Name of car middle initial) Yes 1 ling Physiciand submit pendent wa	e claim rier No an's or with this s worki	number a Coroner's s claim. ng?	and na	Relate	f carrie	er. to plan i	member	
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Yes No Claim number Deceased dependent's Was this death ac f "Yes", please ha Statement (page S Did the accident o Yes No Location of accident For Optional Life o Yes No Plan member insurance class	If "Yes", ple s name (last, first, f ccidental? ( ave the Attend 9) completed a pccur while dep If "Yes", ple only - If claim i	Address of a ach copy of date of plan	e claim rier No an's or with this cation a ccident e, was f declar	number a Coroner's s claim. ng? and addre depender	Dat Dat ess of nt spo	Relative of according according use in	f carrie tionship cident (d ent.	to plan i d/mmm,	member /yyyyy) n-smoke	
Yes       No         Claim number       No         Deceased dependent's         Mas this death ac         f "Yes", please ha         Statement (page S         Did the accident of         Yes       No         Location of accident         For Optional Life of         Yes       No         Plan member insurance class (if applicable)       Most met         certify that the in       No	If "Yes", ple s name (last, first, f ccidental? ( ave the Attend 9) completed a pccur while dep If "Yes", ple only - If claim i If "Yes", att st recent effective mber's coverage (c	ease provide Name of car middle initial) Yes I ling Physiciand submit pendent water ease give lo Address of a is for spous ach copy of date of plan dd/mmm/yyyy)	e claim rier No an's or with this as worki cation a ccident e, was f declar Origin covera	number a Coroner's s claim. ng? and addre depender ation. al effective c age (dd/mmr	and na Dat ess of nt spo date of o n/yyyy)	Relative of according according to the beside the besid	tionship cident (d ent. nsured ent's D (c st of m	to plan i d/mmm, at noi Pate to w dd/mmm	member /yyyy) n-smoke /hich pren /yyyy) wledge.	niums were pai
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#### For plan sponsor administered groups only. Please submit COPY

enrolment form for this plan member.

Declaration

2	Plan member's statement for death of a dependent	Deceased dependent's address (number, s	street)	City		Province	Postal code
		Deceased's date of birth (dd/mmm/yyyy)	Deceased's	marital status	If deceased wa name institutio	as a dependent o on	child and attending school,
		Cause of death				Date of death	n (dd/mmm/yyyy)
		If deceased died in hospital, pleas	se give da	te admitted	•	(dd/mmm/yyy	/у)
		At time of death, was the dependence of Yes No If "Yes," indic		yed? er of hours wor		nours per week	
		Was he/she dependent on you fo			No		
		Was the dependent confined to a	hospital v (dd/mmm/	-	became effe	ective?	
		If "Yes," indicate date discharged					
	Please provide the following information regarding YOURSELF.	Your name (last, first, middle initial)					
		Your Social Insurance Number — — —	Relation	ship to deceased			
	Plan member's certification and authorization for all death claims	I certify that the statements provi belief. I, the undersigned, hereby make	-		-		
		(name of deceased)			-		
		I understand Manulife Financial may care professional, hospital, health car medically-related facility, insurance c institution, association or person, Pol medical, or any other information or r may be requested by Manulife Finance I authorize the use of my Social Insur number is used as my certificate num benefits. I agree that a photocopy of this author	re institution ompany, gr ice authorit records incl cial to proce rance Numl nber, I auth	n, medical organi roup plan adminis ies or coroner, to uding Police inve ess this claim. ber for the purpos orize it's use for t	ization, clinic strator, or any release and stigation, auto se of tax repo the identificati	and any other other corpora exchange with opsy or corone rting and if my	medical or tion, organization, Manulife Financial any er's inquest reports that social insurance
	Plan member's signature	Plan member's signature <b>X</b>				Dates	signed (dd/mmm/yyyy)
		At Manulife Financial, we know that of to us will be kept in a group life and h •our employees and service represer •persons to whom you have granted •persons authorized by law. You have the right to request access	ealth bene ntatives in t access; an	fits file. Access to he performance o d	o this informat of their jobs;	tion will be limi	ted to:

### 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)	Acco	Account/Division number Union local Cert			Certificate	Certificate number	
	Plan administrator's name (last, first, middle initial)							
	Plan administrator's mailing address (number, street) City			Province	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					at death		
	Residence address at death (num	ber, street)	treet) City		Province	e 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) (a)			betweer	n onset a	and death		
					<b>Interval</b> (b)	Interval between onset and death (b)		
	Due to (c)			(c)	(c)			
	To your knowledge, did the deceased ever smoke?       Number of years         Yes       No       I don't know       If "Yes", how many years?							
	Date of first attendance (dd/mmm/yyyy) Date of last a in last illness							
	If death was due to accident, suicide or homicide, specify which and describe briefly.							
	Was an inquest held?	) Yes 🔵 No	Was an	autopsy p	erformed?	⊖ 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 la 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 i	illness/injury		oproximat d/mmm/yyy	
						(d	d/mmm/yyy	y)

# Attending physician's personal information

Attending	physician's
signature	

Attending physician's full name	Degree or qualification			
Address (number, street)	City	Province	Postal code	
Area code and phone number ( )				
Attending physician's signature X		Date signed (	dd/mmm/yyyy)	

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.

### 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/Divis	sion number	Union local	Certificate number		
	Plan administrator's name (last, first, middle initial)						
	Plan administrator's mailing address (number, street) City Provin				e Postal code		
Attending physician's or coroner's statement for accidental death	Deceased's name (last, first, middle initial)	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?						
	Were there any contributing or remo		death?				
	Was the injury, described above, by itself and independent of all other causes, sufficient to cause death?						
	At the time of the injury, was the dec Yes No If "Yes," please Blood alcohol content Type of	show blood	the influence o alcohol content				
	Was an autopsy performed?	es 🔿 No					

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 X			Date signed (dd/mmm/yyyy)		
	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.					