Manulife Financial

Group Benefits
Group Survivor Claim

Note: Copies of the following documents must accompany this form:

- ***birth certificates of the plan member, spouse and all eligible children***
- ***marriage certificate or affidavit of co-habitation of spouse***
- ***proof of school attendance of children if attendance at school is required by the group contract.***

1 Plan administrator's statement

Plan contract number	**Division no.**	**Class**	**Union local**	**Plan member certificate number(s)**

Plan sponsor name	Telephone number ( )

1. Address of plan sponsor (number, street)	City	Province	Postal code

2. Name of plan member (last, first, middle initial)	Occupation

3. Address of plan member (number, street)	City	Province	Postal code

4. Date of birth (dd/mmm/yyyy)	5. Date of employment (dd/mmm/yyyy)	6. Actual date last worked (dd/mmm/yyyy)

7. If date last worked was other than date of death, give reason (check one):
◯ Disability ◯ Leave of absence ◯ Dismissed ◯ Retired
◯ Strike/Layoff ◯ Severance ◯ Resigned

8. Salary at date last worked (exclude commissions, bonus and overtime) ◯ Hourly ◯ Salaried $	If commissions, bonuses or overtime are included in salary for insurance purposes, provide:			
	Year to date	Previous three calendar years		
		Year	Year	Year
Regular number of hours worked per week:	$	$	$	$

9. Plan member was:
◯ Permanent ◯ Full time ◯ Temporary ◯ Part time

10. Date of death (dd/mmm/yyyy)	11. Cause of death

12. Effective date of insurance (dd/mmm/yyyy)	13. Monthly benefit amount $	Date of last change (dd/mmm/yyyy)

Plan administrator's certification and authorization

I certify that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. The information in this statement will be kept in a group life, health, or disability benefits file with Manulife Financial and might be accessible by the plan member or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.

Signature of plan administrator	Date signed (dd/mmm/yyyy)

2 Claimant's statement

Part A - Statement of surviving spouse

1. Name of surviving spouse (last, first, middle initial) ◯ Male ◯ Female		Telephone number ( )

2. Address of surviving spouse (number, street) ◯ SAME AS PLAN MEMBER	City	Province	Postal code

3. Date of birth (dd/mmm/yyyy)	4. Social Insurance Number	5. Were you living apart from the plan member at the time of death? ◯ Yes ◯ No

If Yes to question 5, under what circumstances did the separation exist?

2 Claimant's statement (continued)

Part A - Statement of surviving spouse (continued)

I certify that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. I hereby claim the Group Survivor Insurance proceeds payable as a result of the death of

_____

(name of deceased)

Manulife Financial will investigate this claim and may require personal information related to the deceased's health, employment, police investigations, and autopsy or coroners inquest reports.
I authorize any person or organization who has personal information pertaining to this claim, including any employer, group plan administrator, health care professional, health care institution, and any other medically-related facility, insurer, police, coroner and investigative agency, to release personal information pertaining to this claim to Manulife Financial and/or its service providers for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of this claim.
I authorize Manulife Financial, its reinsurers and its service providers to collect, to use, to maintain and to disclose to the persons or organizations listed above and/or each other any information needed for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of this claim.
I authorize the use of my Social Insurance Number for the purposes of tax reporting.
I agree that a photocopy or electronic version of this authorization shall be as valid as the original.
I understand that Manulife Financial's Privacy Policy and related materials on how and why Manulife Financial collects, uses, maintains and discloses my personal information, is available upon request; on Manulife Financial's Web site: www.manulife.ca, or through my Plan Sponsor.
I understand that any personal information provided to or collected by Manulife Financial in accordance with this authorization, will be kept in a group life, health, or disability benefits file. Access to my personal information will be limited to:

- Manulife Financial employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom I have granted access; and
- Persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

Signature of spouse	Date signed (dd/mmm/yyyy)

Part B - Statement of claimant for eligible children

To be completed by the surviving spouse, or if there is no spouse, by the guardian or other claimant on behalf of the children.

Name of children	Complete address	Date of birth (dd/mmm/yyyy)	Attending school	If Yes, name and address of school
			◯ Yes ◯ No	
			◯ Yes ◯ No	
			◯ Yes ◯ No	

Relationship of claimant to eligible children (*If Guardian or Other, provide your relationship to children and attach legal proof*)

◯ Mother ◯ Father ◯ Guardian ◯ Other

Full name and address of claimant if other than surviving spouse

Claimant's certification and authorization for all death claims

I certify that the children listed above are the unmarried children of the Plan Member. I certify that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. I hereby claim the Group Survivor Insurance proceeds payable as a result of the death of

_____

(name of deceased)

Manulife Financial will investigate this claim and may require personal information related to the deceased's health, employment, police investigations, and autopsy or coroners inquest reports.
I authorize any person or organization who has personal information pertaining to this claim, including any employer, group plan administrator, health care professional, health care institution, and any other medically-related facility, insurer, police, coroner and investigative agency, to release personal information pertaining to this claim to Manulife Financial and/or its service providers for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of this claim.
I authorize Manulife Financial, its reinsurers and its service providers to collect, to use, to maintain and to disclose to the persons or organizations listed above and/or each other any information needed for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of this claim.
I authorize the use of my Social Insurance Number for the purposes of tax reporting.
I agree that a photocopy or electronic version of this authorization shall be as valid as the original.
I understand that Manulife Financial's Privacy Policy and related materials on how and why Manulife Financial collects, uses, maintains and discloses my personal information, is available upon request; on Manulife Financial's Web site: www.manulife.ca, or through my Plan Sponsor.
I understand that any personal information provided to or collected by Manulife Financial in accordance with this authorization, will be kept in a group life, health, or disability benefits file. Access to my personal information will be limited to:

- Manulife Financial employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom I have granted access; and
- Persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

Signature of claimant	Date signed (dd/mmm/yyyy)	Name of claimant (please print)