Equitable Life of Canada®

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GROUP DEPENDENT LIFE CLAIM - STATEMENT OF EMPLOYER

1. Name of Insured: _____

2. Group Policy No.: _____ Certificate No.: _____

3. Occupation: _____

4. Prior to date of claim, date employee last at work on a full-time basis:	DD / MM / YYYY
5. Is the employee retired? Yes☐ No☐ If so, date of retirement:	DD / MM / YYYY

6. Was the employee working the required minimum number of hours per week, to be eligible on this plan? Yes☐ No☐

7. Name of Deceased: Relationship:

8. Date of Death:	DD / MM / YYYY

9. Cause of Death:

10. If the insured's dependent is a child over the age of 18, please complete the following (if applicable):

i) Date full-time schooling was to have been completed:	DD / MM / YYYY
ii) Date dependent became employed full time:	DD / MM / YYYY

iii) Dependent unmarried at the time of death?: Yes☐ No☐

11. Other:

Date: _____ Employer Name: _____

Signature and Title: _____