Equitable™

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GROUP LIFE PLAN SPONSOR CLAIM FORM

To be completed by the employer or plan administrator.

Employee Data

Member's last name: _____ First name: _____ Date of birth: _____ (mm/dd/yyyy)

Address: _____ (Street number and name) City: _____ Province: _____ Postal Code: _____

Policy number: _____ Certificate number: _____

Group Life Claim

Member's last name: _____ First name: _____ Date of birth: _____ (mm/dd/yyyy)

Address: _____ (Street number and name) City: _____ Province: _____ Postal Code: _____

Date employment commenced: _____ (mm/dd/yyyy) Date last worked prior to death: _____ (mm/dd/yyyy)

If not actively at work at death, state reason: ☐ Sick leave
☐ Retired
☐ Other (specify) _____
Date of absence: _____

Current Salary*: $_____ Date of death: _____ (mm/dd/yyyy) Cause of death: ☐ Accident (Further details may be required)
☐ Other (specify) _____
☐ Unknown at present

* Please note: As outlined in your Group Policy, if the current salary differs from the amount on your last billing statement, we will consider the lesser of the current salary and the billed amount.

Group Dependent Life Claim

Deceased's last name: _____ First name: _____ Date of birth: _____ (mm/dd/yyyy)

Address: _____ (Street number and name) City: _____ Province: _____ Postal Code: _____

Date of death: _____ (mm/dd/yyyy) Relationship to employee: ☐ Spouse
☐ Common-Law Spouse
☐ Child
☐ Other (specify) _____

Dependent Life Insurance amount: $_____ Cause of death: ☐ Accident (Further details may be required)
☐ Other (specify) _____

Employees date of hire: _____ (mm/dd/yyyy) Was employee actively at work at death of dependent? ☐ Yes ☐ No

If employee was not actively at work at death, date last worked and reason: _____ (mm/dd/yyyy) ☐ Sick leave
☐ Retired
☐ Other (specify) _____

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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: _____ mm/dd/yyyy

ii. Date dependent became employed full time: _____ mm/dd/yyyy

iii. Dependent unmarried at time of death? ☐ Yes ☐ No

Employer Information

Group Policyholder name: _____

Address: _____ City: _____ Province: _____ Postal Code: _____
Street number and name

Authorized Signature: _____ Print Name: _____

Telephone number: _____ Email: _____

Location signed (city, province): _____

Date: _____
mm/dd/yyyy

Fax this completed form, along with any other pertinent documentation to 1 888 505 4373
or mail to **(do not use staples)**:

Equitable
Group Disability Claims Department
One Westmount Road North
P.O. Box 1603 Stn Waterloo, Waterloo Ontario N2J 4C7

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