



GROUP LIFE & DEPENDENT LIFE CLAIM - STATEMENT OF EMPLOYER

To be completed by the employer or plan administrator.

Employee Data

Member's last name: _____ First name: _____ Date of birth: _____
mm/dd/yyyy
Address: _____ City: _____ Province: _____ Postal Code: _____
Street number and name
Policy number: _____ Certificate number: _____

Group Life Claim

Member's last name: _____ First name: _____ Date of birth: _____
mm/dd/yyyy
Address: _____ City: _____ Province: _____ Postal Code: _____
Street number and name
Date employment commenced: _____ Date last worked prior to death: _____
mm/dd/yyyy 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: _____ Cause of death: Accident (Further details may be required)
mm/dd/yyyy 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: _____ City: _____ Province: _____ Postal Code: _____
Street number and name
Date of death: _____ Relationship to employee: Spouse
mm/dd/yyyy Common-Law Spouse
 Child
 Other (specify) _____
Dependent Life Insurance amount: \$ _____ Cause of death: Accident (Further details may be required)
 Other (specify) _____
Employee's date of hire: _____ Was employee actively at work at death of dependent? Yes No
mm/dd/yyyy
If employee was not actively at work at death, date last worked and reason: _____ Sick leave
mm/dd/yyyy 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 Life of Canada
Group Disability Claims Department
One Westmount Road North
P.O. Box 1603 Stn Waterloo, Waterloo Ontario N2J 4C7

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