



## GROUP LIFE CLAIM – CLAIMANT’S STATEMENT

### Instructions

1. If the policy is payable to a named beneficiary or beneficiaries:
  - a) This statement should be completed by the named beneficiary, unless a minor.
  - b) If there is more than one beneficiary, each beneficiary should complete a separate Claimant’s Statement.
  - c) If any named beneficiary is a minor, this statement should be completed, on behalf of the minor beneficiary, by the named trustee.
  - d) If a trustee was not named for a minor beneficiary, by the guardian or other person authorized by law to deal with the minor’s property. A certified copy of the Letters of Guardianship must be submitted.
2. If the policy is payable to the Estate the cheque will be payable to “The Estate”.

### Limitation Period

A limitation period provision describes the time period in which you may commence a proceeding for recovery of policy benefits. This time period is set out in provincial insurance legislation or other legislation that applies to your claim.

### Information about the claimant

Claimant’s last name: \_\_\_\_\_ First name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Street number and name  
 Telephone number: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Relationship to deceased: \_\_\_\_\_  
 Claimant’s basis of claim:  Named beneficiary  Trustee  Beneficiary’s Guardian  
 Estate Representative  Other, please specify: \_\_\_\_\_

### Information about the deceased

Is the deceased the:  Member  Spouse  Dependent Policy number: \_\_\_\_\_  
 Deceased’s last name: \_\_\_\_\_ First name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apartment or suite: \_\_\_\_\_  
Street number and name  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Social Insurance Number: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Marital status at death: \_\_\_\_\_  
mm/dd/yyyy  
 Cause of death (specific): \_\_\_\_\_ Relationship to member (if not member): \_\_\_\_\_  
 Place of death: \_\_\_\_\_ Date of death: \_\_\_\_\_  
mm/dd/yyyy  
 Names and addresses of all Physicians who attended the deceased in past 2 years

Name	Address	Date	Reason



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### Authorization & Acknowledgement

I certify that the information given on this form is true, correct and complete.

For the purposes of underwriting, administration, claims processing and adjudication with respect to the Group Policy and any supplementary forms/documents, I authorize The Equitable Life Insurance Company of Canada (“Equitable”), its employees, representatives and service providers to use my personal information, and exchange such personal information with reinsurers, insurers, investigative agencies, health care providers and facilities, and any other person or party whom I authorize.

For the above purposes, I authorize any physician, practitioner or other health care provider, hospital, clinic or other medical facility, pharmacy, insurer, employer (past and present), WSIB/CNESST Workers Compensation plan, medical or benefit payment plan, service provider, and any other institution, person or party that has any record or knowledge of the deceased’s death, to give to Equitable full particulars of such information, including any prior medical history and benefits.

I authorize and direct the Equitable Life Insurance Company of Canada to deduct from the life insurance proceeds payable to me any overpayment of disability benefits paid to the deceased by Equitable Life.

A photocopy of this acknowledgement shall be as valid as the original.

Signature of Witness: \_\_\_\_\_

Name of Witness: \_\_\_\_\_

Location signed (city): \_\_\_\_\_ Location signed (province): \_\_\_\_\_ Date: \_\_\_\_\_  
mm/dd/yyyy

Claimant’s signature: \_\_\_\_\_

Address: \_\_\_\_\_ Apartment or suite: \_\_\_\_\_  
Street number and name

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone number (home): \_\_\_\_\_ Telephone number (office): \_\_\_\_\_

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