



Life Claim

Please see instructions on page 2 for completing this form.

Please select the appropriate Regional Claim Office address for this claim:

- Halifax
- Montreal

Instructions for completion & requirements **PLAN MEMBER LIFE CLAIM** *(please print all answers)*

Complete page 3, 4 & 5 of this form

- Plan administrator complete and sign section 1,
- Claimant complete and sign sections 2, 3 & 4.

Please check for the following requirements:

Proceeds UNDER \$300,000

-
- Original, certified or notarized copy of Funeral Director's Statement of Death, and newspaper death report or obituary notice (if available)

OR

-
- Original, certified or notarized copy of Provincial Death Certificate

OR

-
- Attending Physician's Statement (page 9 of this form)

Proceeds \$300,000 and OVER

-
- Original, certified or notarized copy of Provincial Death Certificate

OR

-
- Attending Physician's Statement (page 9 of this form)

Accidental Death

-
- Attending Physician's or Coroner's Statement (page 11 of this form)

Plan sponsor administered group (if you maintain the eligibility records for the plan member, please complete the section for plan sponsor administered groups)

-
- ORIGINAL of the Plan Member Enrolment form

 DEPENDANT LIFE CLAIM *(please print all answers)*

Complete page 6, 7 & 8 of this form

- Plan administrator complete and sign section 1,
- Claimant complete and sign sections 2, 3 & 4.

Please check for the following requirements:

Proceeds UNDER \$300,000

-
- Original, certified or notarized copy of Funeral Director's Statement of Death, and newspaper death report or obituary notice (if available)

OR

-
- Original, certified or notarized copy of Provincial Death Certificate

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- Attending Physician's Statement (page 9 of this form)

Proceeds \$300,000 and OVER

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- Original, certified or notarized copy of Provincial Death Certificate

OR

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- Attending Physician's Statement (page 9 of this form)

Accidental Death (if applicable)

-
- Attending Physician's or Coroner's Statement (page 11 of this form)

Plan sponsor administered group (if you maintain the eligibility records for the plan member, please complete the section for plan sponsor administered groups)

-
- COPY of the Plan Member Enrolment form

Miscellaneous requirements

Payments to minor beneficiary

-
- ORIGINAL or NOTARIZED copy of Court appointment of Guardianship of the Estate of the Minor

Payments to estate

-
- ORIGINAL or NOTARIZED copy of the Probated Will or Letters of Administration for proceeds \$50,000 and over.

Beneficiary has died before the plan member

-
- ORIGINAL, CERTIFIED or NOTARIZED copy of deceased Beneficiary's Proof of Death

Please submit this claim to the appropriate address:

Group Benefits Plan Member Claim

Life and Accidental Death (if applicable)

For dependant death claim use pages 6, 7 & 8. Please print clearly

1 Plan administrator's statement for death of plan member

Plan contract number(s)	Account/Division number	Class	Union local	Plan member certificate number
Plan sponsor's name			Deceased plan member's job title	
Deceased plan member's name (last, first, middle initial)				Date of birth (dd/mmm/yyyy)
Date of employment (dd/mmm/yyyy)	Beneficiary's name (last, first, middle initial)			Relationship
Check applicable benefit(s) and specify face amounts				
<input type="radio"/> Basic Life \$ _____		<input type="radio"/> Paid Up Life \$ _____		<input type="radio"/> Basic Accidental Death \$ _____
<input type="radio"/> Optional Life \$ _____		<input type="radio"/> Permanent Paid Up Life \$ _____		<input type="radio"/> Optional Accidental Death \$ _____
Date last worked (dd/mmm/yyyy)	Salary as of last day worked \$ _____	<input type="radio"/> Annually	<input type="radio"/> Semi-monthly	<input type="radio"/> Weekly
		<input type="radio"/> Monthly	<input type="radio"/> Bi-weekly	<input type="radio"/> Hourly
Regular number of hrs. worked/week	Salary effective date (dd/mmm/yyyy)	Date of death (dd/mmm/yyyy)	Date of termination (if applicable) (dd/mmm/yyyy)	
Did the plan member contribute part of the premium payment? <input type="radio"/> Yes <input type="radio"/> No				
If death occurred after date last actively at work, please indicate status:				
<input type="radio"/> Retired	<input type="radio"/> Temporary layoff	<input type="radio"/> Dismissed		
<input type="radio"/> Disabled	<input type="radio"/> Leave of absence	<input type="radio"/> Resigned		
If plan member was disabled prior to death, was any claim for disability benefits filed during this period?				
<input type="radio"/> Yes	<input type="radio"/> No	If "Yes", please provide claim number and name of carrier		
Claim number		Name of carrier		
Was this death accidental? <input type="radio"/> Yes <input type="radio"/> No				
If "Yes", please have the Attending Physician's or Coroner's Statement (page 11) completed and submit with this claim.				Date of accident (dd/mmm/yyyy)
Did the accident occur while plan member was working?				
<input type="radio"/> Yes	<input type="radio"/> No	If "Yes", please give location and address of accident.		
Location of accident		Address of accident		
For Optional Life only - Was plan member insured at non-smoker rates?				
<input type="radio"/> Yes	<input type="radio"/> No	if "Yes", attach copy of declaration		
Most recent effective date of plan member's coverage (dd/mmm/yyyy)		Original effective date of plan member's coverage (dd/mmm/yyyy)		Date to which premiums were paid (dd/mmm/yyyy)
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 Benefits life, health, or disability file with Manulife Financial and might be accessible by the claimant or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.				
Authorized signature X			Date signed (dd/mmm/yyyy)	Area code and phone number
Mailing address (number, street)			City	Province
			Postal code	

For plan sponsor administered groups only:

If you maintain the eligibility records for the plan member please fill out this section and submit **ORIGINAL** enrolment form for this plan member.

Plan administrator's declaration

2 Claimant's statement for death of a plan member

IF DEATH WAS ACCIDENTAL, please answer the following questions. Use a separate sheet of paper if required. If not accidental, please read and sign below.

Please provide the names and addresses of any witnesses to the accident

Relationship to deceased plan member	Plan numbers of other Manulife Financial plans for which a claim is being made
Cause of death	
Date of accident (dd/mmm/yyyy)	Time of accident <input type="radio"/> A.M. <input type="radio"/> P.M.
Fully describe the accident; where was the deceased and what was he/she doing at the time of the accident?	
Name(s)	Address(es)
Did the deceased ever suffer from fainting spells or any bodily or mental disorder? <input type="radio"/> Yes <input type="radio"/> No If "Yes", please explain fully.	

3 Settlement account (Manulife Bank Safe Access Account)

Manulife Financial is pleased to offer a unique settlement option for insurance policy proceeds. Qualifying beneficiaries may have their insurance policy proceeds deposited directly into a high-interest chequing account (called the Safe Access Account) with our affiliate company, Manulife Bank of Canada ("Manulife Bank"). This account provides you with easy access to your funds with free cheque writing and no monthly maintenance fees.

Eligibility requirements

This payment option is not available:

- If total insurance proceeds from a Manulife group policy are less than \$5,000.
- To minors, courts, trusts, estates, corporations, partnerships or other entities.
- For some insurance products or Group Benefits plans.

Any claims or claimants that are not eligible for this form of payment or indicate that they do not want a Safe Access Account will be paid their proceeds by cheque. If you need assistance or would like to discuss other payment options which are available, please contact the appropriate Group Benefits Life Claims Office:

Halifax (902) 453-4300 or 1-866-447-4517
 Montreal (514) 288-6268 or 1-866-236-6313

4 Claimant's personal information

Claimant's name (last, first, middle initial)		Claimant's phone number	
Claimant's mailing address (number, street)	City	Province	Postal code
Claimant's date of birth (dd/mmm/yyyy)	Claimant's Social Insurance Number		

Claimant's certification and authorization for all death claims

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 agree** that my claim may be denied as a result of my providing false, incomplete, or misleading information. **I hereby** claim the group life insurance proceeds payable as a result of the death of the deceased

(name of deceased)

I understand that Manulife Financial ("Manulife") and its reinsurer will investigate this claim and may require information related to the deceased's health, employment, police investigations, autopsy or coroners inquest reports (collectively referred to in this authorization as "Information"). **I authorize** any person or organization who has 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 and exchange Information requested by Manulife, its reinsurers and its claims service providers for the purpose of benefits plan administration, investigation and management of this claim ("Purposes"). **I authorize** Manulife, its reinsurers and/or claim service providers to collect, use, maintain and disclose to the persons or organizations listed above and/or each other any Information needed for the Purposes. **I authorize** the use of my Social Insurance Number for tax reporting. **I agree** that a photocopy or electronic version of this authorization shall be as valid as the original.

I authorize Manulife to share necessary information regarding me or my claim with Manulife Bank, for the purpose of opening a Safe Access Account ("SAA"), if I am eligible for such an account.

Manulife Bank Safe Access Account Terms and Conditions

If I am eligible for an SAA, **I authorize** Manulife Bank to obtain, verify, give, share and exchange personal information about me, now and in the future, with any individuals, financial institutions, business corporations or other parties with whom I have, or propose to have, financial or personal dealings, or who hold information about such dealings, such as credit bureaus. My personal information will be used for the purpose of confirming my identity and the accuracy of the information I provide. Manulife Bank may collect information with this consent for the purposes of administering and maintaining my financial records and as may be otherwise permitted or required by law. **I authorize** any person that Manulife Bank contacts under this authorization to provide such information about me. **I authorize** Manulife Bank to record my telephone conversations for the administration of my SAA and to maintain quality service levels. If I do not wish that my telephone conversations be recorded, **I agree** only to communicate with Manulife Bank in writing and request that any response by Manulife Bank be in writing as well. **I understand** that information relating to Manulife Bank's privacy policy is available at www.manulifebank.ca or by calling 1-877-765-2265.

By signing this form, **I agree and acknowledge** that, if I meet the eligibility requirements for the SAA and if I have not made alternative payment arrangements:

- An SAA will be opened for me and my insurance claim proceeds will be deposited to this account;
- Manulife Bank will provide me with the following documents:
 - (a) an SAA Operating Agreement ("Operating Agreement") which will set out the terms and conditions for the operation of the SAA;
 - (b) a brochure that sets out the fees and other charges applicable to my SAA (the "Brochure");
- **I agree** to be bound by the Operating Agreement and the fees set out in the Brochure;
- **I agree** to provide my Social Insurance Number as it is required for tax reporting; and
- **I understand** that Manulife Bank may change its interest rates from time to time and interest rate changes will be posted at www.manulifebank.ca or by calling 1-877-765-2265.

I understand that any personal information provided to or collected by Manulife 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 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 understand that Manulife's privacy policy is available at www.manulife.ca or upon request. **I understand** that I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

I understand that if I do not consent to the use of my personal information as outlined above, I may contact the appropriate Group Benefits Life Claims Office to arrange an alternative payment method:
Halifax (902) 453-4300 or 1-866-447-4517
Montreal (514) 288-6268 or 1-866-236-6313

Claimant's signature

Claimant's signature	Date signed (dd/mmm/yyyy)
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Group Benefits Dependant Claim Life and Accidental Death (if applicable)

For plan member death claim use pages 3, 4 & 5. Please print clearly.

1 Plan administrator's statement for death of dependant – plan member details

Plan contract number(s)	Account/Division number	Class	Union local	Plan member certificate number
Plan sponsor's name			Employer's name (if different from plan sponsor)	
Plan member's name (last, first, middle initial)				Date of birth (dd/mmm/yyyy)
Plan member's mailing address (number, street)			City	Province Postal code
Date of employment (dd/mmm/yyyy)		Job title		
Check applicable benefit(s) and specify face amounts				
<input type="radio"/> Basic Life \$ _____		<input type="radio"/> Basic Accidental Death \$ _____		<input type="radio"/> Paid Up Life \$ _____
<input type="radio"/> Optional Life \$ _____		<input type="radio"/> Optional Accidental Death \$ _____		
Date last worked (dd/mmm/yyyy)	Salary as of last day worked \$ _____	<input type="radio"/> Annually <input type="radio"/> Monthly	<input type="radio"/> Semi-monthly <input type="radio"/> Bi-weekly	<input type="radio"/> Weekly <input type="radio"/> Hourly
Regular number of hrs. worked/week	Salary effective date (dd/mmm/yyyy)	Date of death (dd/mmm/yyyy)	Date of termination (if applicable) (dd/mmm/yyyy)	
If death occurred after date last actively at work, please indicate status:				
<input type="radio"/> Retired		<input type="radio"/> Temporary layoff		<input type="radio"/> Dismissed
<input type="radio"/> Disabled		<input type="radio"/> Leave of absence		<input type="radio"/> Resigned
If plan member was disabled prior to death, was any claim for disability benefits filed during this period?				
<input type="radio"/> Yes		<input type="radio"/> No If "Yes", please provide claim number and name of carrier		
Claim number		Name of carrier		
Deceased dependant's name (last, first, middle initial)				Relationship to plan member
Was this death accidental? <input type="radio"/> Yes <input type="radio"/> No				
If "Yes", please have the Attending Physician's or Coroner's Statement (page 11) completed and submit with this claim.				Date of accident (dd/mmm/yyyy)
Did the accident occur while dependant was working?				
<input type="radio"/> Yes		<input type="radio"/> No If "Yes", please give location and address of accident.		
Location of accident		Address of accident		
For Optional Life only - If claim is for spouse, was dependant spouse insured at non-smoker rates?				
<input type="radio"/> Yes		<input type="radio"/> No if "Yes", attach copy of declaration		
Most recent effective date of plan member's coverage (dd/mmm/yyyy)	Original effective date of dependant's coverage (dd/mmm/yyyy)	Date to which premiums were paid (dd/mmm/yyyy)		
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 Benefits life, health, or disability file with Manulife Financial and might be accessible by the claimant or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.				
Authorized signature X		Date signed (dd/mmm/yyyy)		Area code and phone number
Mailing address (number, street)			City	Province Postal code

For plan sponsor administered groups only:

If you maintain the eligibility records for the plan member please fill out this section and submit **ORIGINAL** enrolment form for this plan member.

Plan administrator's declaration

2 Plan member's statement for death of a dependant

Deceased dependant's address (number, street)		City	Province	Postal code
Deceased's date of birth (dd/mmm/yyyy)	Deceased's marital status <input type="radio"/> Married <input type="radio"/> Single		If deceased was a dependant child and attending school, name institution	
Cause of death			Date of death (dd/mmm/yyyy)	
If deceased died in hospital, please give date admitted		(dd/mmm/yyyy)		
At time of death, was the dependant employed? <input type="radio"/> Yes <input type="radio"/> No If "Yes," indicate number of hours worked			Number of hours per week	
Was he/she dependent on you for support? <input type="radio"/> Yes <input type="radio"/> No				
Was the dependant confined to a hospital when coverage became effective? <input type="radio"/> Yes <input type="radio"/> No If "Yes," indicate date discharged			(dd/mmm/yyyy)	

3 Settlement account (Manulife Bank Safe Access Account)

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Eligibility requirements

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- If total insurance proceeds from a Manulife group policy are less than \$5,000.
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Any claims or claimants that are not eligible for this form of payment or indicate that they do not want a Safe Access Account will be paid their proceeds by cheque. If you need assistance or would like to discuss other payment options which are available, please contact the appropriate Group Benefits Life Claims Office:

Halifax (902) 453-4300 or 1-866-447-4517
 Montreal (514) 288-6268 or 1-866-236-6313

4 Claimant's personal information

Claimant's name (last, first, middle initial)		Claimant's phone number	
Claimant's mailing address (number, street)	City	Province	Postal code
Claimant's date of birth (dd/mmm/yyyy)	Claimant's Social Insurance Number		

Claimant's certification and authorization for all death claims

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 agree** that my claim may be denied as a result of my providing false, incomplete, or misleading information. **I hereby** claim the group life insurance proceeds payable as a result of the death of the deceased

(name of deceased)

I understand that Manulife Financial ("Manulife") and its reinsurer will investigate this claim and may require information related to the deceased's health, employment, police investigations, autopsy or coroners inquest reports (collectively referred to in this authorization as "Information"). **I authorize** any person or organization who has 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 and exchange Information requested by Manulife, its reinsurers and its claims service providers for the purpose of benefits plan administration, investigation and management of this claim ("Purposes"). **I authorize** Manulife, its reinsurers and/or claim service providers to collect, use, maintain and disclose to the persons or organizations listed above and/or each other any Information needed for the Purposes. **I authorize** the use of my Social Insurance Number for tax reporting. **I agree** that a photocopy or electronic version of this authorization shall be as valid as the original.

I authorize Manulife to share necessary information regarding me or my claim with Manulife Bank, for the purpose of opening a Safe Access Account ("SAA"), if I am eligible for such an account.

Manulife Bank Safe Access Account Terms and Conditions

If I am eligible for an SAA, **I authorize** Manulife Bank to obtain, verify, give, share and exchange personal information about me, now and in the future, with any individuals, financial institutions, business corporations or other parties with whom I have, or propose to have, financial or personal dealings, or who hold information about such dealings, such as credit bureaus. My personal information will be used for the purpose of confirming my identity and the accuracy of the information I provide. Manulife Bank may collect information with this consent for the purposes of administering and maintaining my financial records and as may be otherwise permitted or required by law. **I authorize** any person that Manulife Bank contacts under this authorization to provide such information about me. **I authorize** Manulife Bank to record my telephone conversations for the administration of my SAA and to maintain quality service levels. If I do not wish that my telephone conversations be recorded, **I agree** only to communicate with Manulife Bank in writing and request that any response by Manulife Bank be in writing as well. **I understand** that information relating to Manulife Bank's privacy policy is available at www.manulifebank.ca or by calling 1-877-765-2265.

By signing this form, **I agree and acknowledge** that, if I meet the eligibility requirements for the SAA and if I have not made alternative payment arrangements:

- An SAA will be opened for me and my insurance claim proceeds will be deposited to this account;
- Manulife Bank will provide me with the following documents:
 - (a) an SAA Operating Agreement ("Operating Agreement") which will set out the terms and conditions for the operation of the SAA;
 - (b) a brochure that sets out the fees and other charges applicable to my SAA (the "Brochure");
- **I agree** to be bound by the Operating Agreement and the fees set out in the Brochure;
- **I agree** to provide my Social Insurance Number as it is required for tax reporting; and
- **I understand** that Manulife Bank may change its interest rates from time to time and interest rate changes will be posted at www.manulifebank.ca or by calling 1-877-765-2265.

I understand that any personal information provided to or collected by Manulife 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 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 understand that Manulife's privacy policy is available at www.manulife.ca or upon request. **I understand** that I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

I understand that if I do not consent to the use of my personal information as outlined above, I may contact the appropriate Group Benefits Life Claims Office to arrange an alternative payment method:
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Montreal (514) 288-6268 or 1-866-236-6313

Claimant's signature

Claimant's signature	Date signed (dd/mmm/yyyy)
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Group Benefits Attending Physician's Report

If there is a charge for the completion of this form, payment is the responsibility of the claimant. Please print clearly.

Completed reports should be returned to:

Plan contract number(s)	Account/Division number	Union local	Plan member certificate number
Plan administrator's name (last, first, middle initial)			
Plan administrator's mailing address (number, street)	City	Province	Postal code

The Medical Certification follows the recommendation of the World Health Organization. It has been accepted in Canada and the United States. In the interest of accurate vital statistics, please conform to the current International List of Causes of Death. When complete, please return this form to the plan administrator at the address shown above.

Physician's report

Deceased's name (last, first, middle initial)	Place of death	Date of death (dd/mmm/yyyy)	
If death occurred in an institution or hospital, please give name		Age at death	
Residence address at death (number, street)	City	Province	Postal code

Cause of death

Enter only one cause for each of a, b and c.

Disease and condition directly leading to death: (This does not mean the mode of dying such as heart failure, asthenia, etc. It means the disease, injury or complication which caused the death).		Interval between onset and death
(a)		(a)
Antecedent causes. (Morbid conditions, if any, giving rise to the above cause (a) stating underlying causes last).		Interval between onset and death
Due to (b)		(b)
Due to (c)		(c)

To your knowledge, did the deceased ever smoke? Yes No I don't know If "Yes", how many years?

Date of first attendance in last illness (dd/mmm/yyyy) Date of last attendance in last illness (dd/mmm/yyyy)

If death was due to accident, suicide or homicide, specify which and describe briefly.

Was an inquest held? Yes No **Was an autopsy performed?** Yes No

If "Yes," to either of the above, by whom and what findings?

Have you treated or advised the deceased during the last five years, prior to last illness? Yes No

Did the deceased, to your knowledge, receive treatment during the last five years from any other physician, or in any hospital or institution? Yes No

If "Yes," to either of the above, please provide the following information.

Name	Address	Nature of illness/injury	Approximate dates (dd/mmm/yyyy)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please complete page 10 of this form.

Attending physician's personal information

Attending physician's full name		Specialty	
Address (number, street)		City	Province
Postal code			
Area code and phone number	Area code and fax number		

Attending physician's signature

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 Benefits life, health, or disability file with Manulife Financial and might be accessible by the claimant or third parties to whom access has been granted or those authorized by law. By providing the information **I consent** to such unedited release of any information contained herein.

Attending physician's signature	Date signed (dd/mmm/yyyy)
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Group Benefits
Attending Physician's or Coroner's Statement for Accidental Death

If there is a charge for the completion of this form, payment is the responsibility of the claimant. Please print clearly.

Completed reports should be returned to:

Plan contract number(s)	Account/Division number	Union local	Plan member certificate number
Plan administrator's name (last, first, middle initial)			
Plan administrator's mailing address (number, street)	City	Province	Postal code

Attending physician's or coroner's statement for accidental death

Deceased's name (last, first, middle initial)	Date of injury (dd/mmm/yyyy)	Date of death (dd/mmm/yyyy)
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What was the precise nature and extent of the injury?

What was the primary or immediate cause of death?

Was the deceased ever treated for a similar condition?

Yes No If "Yes," where and by whom?

Were there any contributing or remote causes of death?

Yes No If "Yes," what were they?

Was the injury, described above, by itself and independent of all other causes, sufficient to cause death?

Yes No If "No," please explain fully.

At the time of the injury, was the deceased under the influence of alcohol or narcotic drugs?

Yes No If "Yes," please show blood alcohol content and/or type of drug.

Blood alcohol content	Type of drug
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Was an autopsy performed? Yes No

Please complete page 12 of this form.

Attending physician's or coroner's personal information

Attending physician's or coroner's full name		Specialty	
Address (number, street)		City	Province
			Postal code
Area code and phone number	Area code and fax number		

Attending physician's or coroner's signature

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 Benefits life, health, or disability file with Manulife Financial and might be accessible by the claimant or third parties to whom access has been granted or those authorized by law. By providing the information **I consent** to such unedited release of any information contained herein.

Attending physician's or coroner's signature	Date signed (dd/mmm/yyyy)
----------------------------------------------	---------------------------