

**GROUP LIFE BENEFITS
 CLAIM FOR ACCIDENTAL DISMEMBERMENT OR LOSS**

Part 1 Employer's or Administrator's Statement

Name of Employee _____

Address _____
 Street City Province Postal Code

Group Policy No. _____ Certificate No. _____ Division No. _____

Total amount of insurance coverage \$ _____

Amount of Accidental Dismemberment or Loss Benefit \$ _____ Date last reported for work prior to accident _____

Salary or wages as of date last reported for work \$ _____ Has the employee returned to work? Yes No

If reason for leaving was other than the accident, please give details _____

Date of employment _____ Name of Group _____

Date _____ By _____
 Signature and Official Title

Part 2 Claimant's Statement

Date of Accident _____ Did the accident take place in the course of Employment? Yes No

Briefly describe how the accident occurred _____

Name of hospital if you were confined _____

Dates of hospitalization _____

Name of Attending Physician _____

Physician's Address _____
 Street City Province Postal Code

Date of first treatment _____
 Please note additional information on the reverse side of this form

I hereby declare that the above statements are true and complete; that, to the best of my knowledge and belief, I have withheld no material facts from the Company.

I expressly consent, authorize and direct any physician, surgeon or any other person who has examined me and every hospital or other institution to which I have applied for, or in which I have received treatment to disclose to the Company or its duly authorized representative any knowledge or information thereby acquired. A photocopy of this authorization shall be valid as the original.

_____ Date _____ Claimant – sign full given names and surname

_____ Social Insurance Number

1. Attach certificate of Attending Physician – Dismemberment or Loss (Form M4442).
2. Attach employee's original Enrolment form and any changes, if you retain this record.