Manulife

Group Benefits
Plan Member Claim

Plan administrator complete and sign section 1.
Claimant complete and sign section 2.
Please print clearly.

Please check for the following requirements:

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

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
- ◯ **Beneficiary has died before the plan member:** ORIGINAL or NOTARIZED/CERTIFIED copy of deceased Beneficiary's Proof of Death

1 Plan administrator's statement for death of plan member

Plan contract number	Division number

Plan sponsor name

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.

◯ Basic Life $ _____ ◯ Basic Accidental Death and Disability $_____

Date last worked (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? ◯ Yes ◯ No

If death occurred after date last actively at work, please indicate status:

◯ Retired ◯ Temporary layoff ◯ Dismissed
◯ Disabled ◯ Leave of absence ◯ Resigned

If plan member was disabled prior to death, was any claim for disability benefits filed during this period?

◯ Yes ◯ No If *yes*, please provide claim number and name of carrier.

Claim number	Name of carrier

Was this death accidental? ◯ Yes ◯ No Please submit supporting documents with this claim.

Date of birth (dd/mmm/yyyy)

Did the accident occur while plan member was working?

◯ Yes ◯ No If *yes*, please give location and address of accident.

Location of accident	Address of accident

Plan member insurance class (if applicable)	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)

For plan sponsor administered groups only.

*Please submit **ORIGINAL** enrolment form for this plan member.*

Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Authorized signature ✘	Date signed (dd/mmm/yyyy)	Area code and phone number

Mailing address (number, street and suite)	City	Province	Postal code

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife Financial and might be accessible by third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.

2 Claimant's statement for death of a plan member

Claimant's name (last, first, middle initial)

Claimant's mailing address (number, street and apartment) | City | Province | Postal code

Relationship to deceased plan member | Claimant's date of birth (dd/mmm/yyyy) | Claimant's Social Insurance Number

Cause of death

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.

Date of accident (dd/mmm/yyyy) | Time of accident ◯ a.m. ◯ p.m.

Fully describe the accident; where was the deceased and what was he/she doing at the time of the accident?

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

Name(s) | Address(es)

Did the deceased ever suffer from fainting spells or any bodily or mental disorder?

◯ Yes ◯ No If *yes*, please explain fully.

Claimant's certification and authorization for all death claims

PRINT

I certify that the information in this form is true and complete, to the best of my knowledge and belief. **I also certify** that any further verbal or written statement provided by me will be true and complete to the best of my ability.
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 will investigate this claim and may require information related to the deceased's health, employment, police investigations, autopsy or coroners inquest reports.
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 Financial and/or its claims service providers for the purpose of administering the group plan and investigating and assessing this claim.
I authorize Manulife Financial, its reinsurers and its claims service providers to collect, to use and to exchange with the persons or organizations listed above and/or each other any information needed for the purpose of administering the group plan and investigating and assessing this claim.
I authorize the use of my Social Insurance Number for the purpose of tax reporting.
I agree that a photocopy or electronic version of this authorization shall be as valid as the original.
I understand that information relating to Manulife Financial's privacy policies is available upon written request, on Manulife Financial's website, www.manulife.ca or through the Plan Sponsor.

I understand that any personal information provided to or collected by Manulife Financial 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 Financial 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 have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

Claimant's signature

Claimant's signature | Date signed (dd/mmm/yyyy)

Please submit this claim to the address below:

Prairie Teamsters Administration Services
155 - 7260 12 ST SE
CALGARY AB T2H 2S5
Tel: (403) 252-6924
Fax: (403) 253-3231