Individual Health Claim for Accidental Death, Dismemberment or Specific Loss

CLAIMANT'S STATEMENT

Name of Policyowner: ______________________________

Address: ______________________________

Policy No.: ______________ ID No.: ______________ Phone No.: ______________

Total amount of accidental insurance coverage: $ ______________ (amount payable for covered loss may be a percentage of total amount covered. Refer to the Table of Benefits for specific amounts)

Date of Birth: ______________ Date of death (if applicable): ______________

Date of Accident: ______________ Did the accident take place in the course of employment?* ☐ Yes ☐ No

Briefly describe how the accident occurred: ______________________________

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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: ______________________________

* If yes, please provide your accident report.

AUTHORIZATIONS AND DECLARATIONS

At Canada Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

I authorize Canada Life, any healthcare provider, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Canada Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I further authorize the use of my social insurance number for income tax reporting. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

I have provided the information on this form in order to obtain payment of proceeds payable to me (in a personal capacity or on behalf of a beneficiary) and I hereby declare that I am legally entitled to receive all or a share of the proceeds payable under the policy. I certify that by making payment to me, Canada Life has met it's obligation to me. By signing below, I confirm that: I have read, understand and agree with the contents on this form . All statements I have made about my claims and are true and complete, my authorization valid until I cancel it in writing, and a photocopy or electronic copy of this authorization is as valid as the original.

Print Name ______________________ Signature ______________________

Date ______________________ Social Insurance Number ______________________

INSTRUCTIONS

1. **ATTACH CERTIFICATE OF ATTENDING PHYSICIAN – DISMEMBERMENT OR LOSS (FORM NO. M4442(IBP).**
2. **ATTACH ACCIDENT REPORT (i.e. POLICE REPORT, ACCIDENT REPORT).**

Please return the fully completed form and supporting documents to:

The Canada Life Assurance Company
Group Life Benefits
PO Box 6000
Winnipeg MB R3C 3A5

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