GROUP LIFE AND ACCIDENTAL DEATH INSURANCE CLAIM FORM

Throughout this form, "Empire Life" means The Empire Life Insurance Company.

Important Information for Completing this Form

Complete this form for all insured employee Life claims of $100,000 and over OR for any Accidental Death claim regardless of the claim amount. Dependant Life claims do not require a Claimant Statement. Please contact us for the requirements of all other Life claims.

If there are multiple beneficiaries a Claimant Statement must be completed for each beneficiary. Only one Group Policyholder Statement and Attending Physician Statement needs to be completed per claim.

The Attending Physician Statement (page 4 of this form) is always required for all Life claims of $100,000 and over and for all Accidental Death claims. It may be required for other Life claims upon request by Empire Life.

In providing this or other claim forms for the convenience of the claimant, Empire Life does not admit any liability or waive its rights. Empire Life reserves the right to require further information and documentation at its discretion.

1. **If the beneficiary is the estate** – The Claimant Statement must be completed by the estate representative.

   If the deceased left a will – The Claimant Statement is to be completed by the executor(s) and a notarial copy of the will submitted. For estates in Québec, please provide (1) notarial copy of will and will searches; or (2) notarial copy of holograph will or will made in presence of witnesses and probate judgement.

   If the deceased did not leave a will – The Claimant Statement must be completed by the administrator of the Estate and a notarial copy of any court issued documents supporting their appointment must be submitted. In Québec, please submit will searches, notarized Declaration of Heirship and Claimant Statement completed by the heir(s).

2. **If the beneficiary is a minor** – The Claimant Statement is to be completed on behalf of the minor beneficiary by the trustee named in the certificate by the insured employee. If no trustee is named, the Claimant Statement should be completed by the legally appointed guardian, or in Quebec by the tutor. A notarial copy of the guardian or tutor appointment must be furnished. In Quebec, payments will be made to the parent as the legal tutor unless the insured employee created a valid trust.

3. **If the beneficiary is deceased** – Satisfactory proof of death of any deceased beneficiary is required (e.g. Death Certificate, Funeral Home Certificate) and proceeds will be payable to the insured employee's estate (see #1 above).

Should you have any questions, please contact us at:

Telephone: 1 800 267-0215

Fax: 613 548-8402 or toll free at 1 855 430-9455

Email: grouplifeanddisability@empire.ca

GROUP LIFE AND ACCIDENTAL DEATH INSURANCE CLAIM FORM

1. Deceased Insured Employee Information

Group policy number	Division number	Certificate number

Name of deceased insured employee (first, middle, last)	Date of death (dd/mmm/yy)

2. Group Policyholder Statement - to be completed by the Plan Administrator

Name of policyholder

Insured employee's last day worked (dd/mmm/yy)	Number of hours worked per week

Reason the employee stopped working:
- ◯ Deceased
- ◯ Disabled
- ◯ Other - please provide details:

Name of beneficiary(ies)	Amount of insurance being claimed $

Signature of authorized company official X	Name and title of authorized company official (please print)

Signed at (city, province)	Date (dd/mmm/yy)

Phone number	Email address

3. Claimant Statement - to be completed by the claimant

I am claiming the proceeds as (check all that apply):

◯ the named beneficiary ◯ the executor on behalf of the estate ◯ the trustee on behalf of a minor beneficiary

Was a will left? ◯ yes ◯ no - if yes, is it being probated? ◯ yes ◯ no

Name of claimant (first, middle, last)

Address (number, street)	City	Province	Postal code

Phone number	Email address

Beneficiary's date of birth (dd/mmm/yy)	Relationship to deceased

Cause of death

Reset Form

Empire Life

4. Executor Information ◯ Same as individual claimant information provided in section 3, or ◯ Unknown, or :

Name of executor (first and last)			
Address (city, number, street)	City	Province	Postal code
Phone number	Email address		

5. Important Information

FRAUD NOTICE

Any person who knowingly files a claim containing any false or misleading information may be subject to criminal and/or civil penalties. In addition, an insurer may deny benefits if false or misleading information materially related to the claim or application for insurance was provided by the applicant or claimant.

LIMITATION PERIOD NOTICE

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (for British Columbia, Alberta and Manitoba), the Limitations Act, 2002 (for Ontario), or other applicable legislation (for all other provinces and territories).

PRIVACY NOTICE

To maintain the confidentiality of your personal information and the personal information of the deceased, Empire Life will establish a file to contain the information provided in the claim. The purpose of this file is to enable Empire Life to assess the claim. This file will be kept in our office and only Empire Life employees, agents, third party service providers or representatives will have access to it when performing their duties. Empire Life may use third party service providers located outside of Canada to process and store the personal information. Personal information that is processed or stored in another jurisdiction may be subject to the laws of that jurisdiction, which may allow disclosure to courts, law enforcement or other government authorities of that jurisdiction under certain circumstances. A copy of the Empire Life privacy policy is available on the website at www.empire.ca.

6. Declaration, Acknowledgement and Authorization

I declare that the information provided in this Claimant Statement is accurate and complete.

I acknowledge I have read and understand Section 4 - Important Information.

I acknowledge that Empire Life is not confirming the validity of any claim or waiving any of its rights in defence of any claim arising under the contract by providing this form, investigating the claim, or by accepting proofs of claim.

I authorize Empire Life, its reinsurers and their respective agents, and any employer, group policy administrator, licensed physician, medical practitioner, hospital, clinic or other medical, paramedical facility, insurance company or other organization, institution or person that has information pertaining to this claim to release and exchange any necessary information for the purpose of administering the group policy and investigating and assessing this claim.

A photocopy or electronic copy of this authorization shall be as valid as the original.

Signature of claimant **X**	
Signed at (city, province)	Date (dd/mmm/yy)

ATTENDING PHYSICIAN STATEMENT
GROUP LIFE AND ACCIDENTAL DEATH INSURANCE CLAIM

To be completed for all insured employee Life claims of $100,000 and over and for all Accidental Death claims.
If there are multiple beneficiaries only one copy of the Attending Physician Statement needs to be submitted.

Any cost incurred in the completion of this form is the responsibility of the Claimant.

TO BE COMPLETED BY THE CLAIMANT		
Group policy number	Division number	Certificate number
Name of deceased (first, middle, last)		Date of death (dd/mmm/yy)
Name of claimant		
I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of the health of the deceased named above to give to Empire Life or its reinsurers any and all information with reference to the health and medical history of the deceased and any hospitalization, advice, diagnosis, treatment, disease, ailment or condition. **I understand that I am responsible for any fees related to the completion of this form.**		
Claimant signature **X**		Date (dd/mmm/yy)

TO BE COMPLETED BY THE PHYSICIAN		
Primary cause of death	Secondary cause of death	
Date of onset of last illness	Date you first attended deceased in last illness	Age at death (or birth date of deceased)
If death was due to an accident, suicide or homicide, specify which and describe briefly:		
Notice to Physician: Any information provided by you to Empire Life regarding this claim will be kept in a life and/or accidental death benefits file and may be disclosed to the claimant and/or those authorized by him/her to receive such disclosure. By providing the information you consent to the unedited release of any information contained herein.		

Name of Physician (please print)		Certified specialty	
Address (number and street)			Physician's stamp
City		Province / Postal code	
Telephone number	Fax number	Email address	
Signature of Physician **X**		Date (dd/mmm/yy)	

Please return this completed form to:

Life & Disability Claims
Group Solutions
The Empire Life Insurance Company
259 King Street East
Kingston ON K7L 3A8

Fax: 1 855 430-9455
Email: grouplifeanddisability@empire.ca