GROUP LIFE AND ACCIDENTAL DEATH INSURANCE CLAIM FORM

Reset Form

See page 2 for important information for completing this form and page 3 for the Attending Physician's Statement (if applicable).

1. Group Policyholder's Statement

Policyholder's name	Group policy number
Name of insured employee (first, middle, last)	Certificate number
We certify that the above insured employee worked _____ (number of hours per week) on _____ (dd/mmm/yy) **OR** was ☐ retired as of, **OR** ☐ disabled as of _____ (dd/mmm/yy).	
Name of deceased	Relationship to insured employee (if Dependant)
Name of beneficiary (if deceased is insured employee)	Amount of Insurance being claimed $
Signed at (City, Province)	Date (dd/mmm/yy)
Signature of Authorized Company Official X	

Name and title of Authorized Company Official (please print)	Phone number	Email address

2. Claimant's Statement

Claimant's name (first, middle, last)		Claimant's phone number
In what capacity or by what title do you claim the insurance proceeds? (e.g. named beneficiary, trustee, executor, tutor, etc.)		
Beneficiary's Social Insurance Number	Beneficiary's date of birth (dd/mmm/yy)	Relationship to deceased
Name of deceased		Deceased's date of birth (dd/mmm/yy)
Cause of death		Date of death (dd/mmm/yy)

Declaration and Authorization:

I, the undersigned, have provided the information on this form in order to obtain payment of insurance 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 insurance proceeds payable under the group policy and certificate number noted above. I certify that, to the best of my knowledge, the answers given in this document and the information in other documents supporting this claim are true and complete. I also certify that any further statement provided by me will be true and complete to the best of my ability.

I, the undersigned, authorize The Empire Life Insurance Company (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.

To maintain the confidentiality of my personal information and the personal information of the deceased, Empire Life will establish a file to contain the information provided in the claim. The objective of this file is to enable Empire Life, its reinsurers and their agents to assess and appraise the claim. This file will be kept at the office of Empire Life and only Empire Life employees, agents or representatives will have access to it when performing their duties. I understand that Empire Life may use third party service providers located within or outside of Canada to process and store my personal information. To access a copy of the most recent Empire Life Privacy Policy, please visit the Empire Life website at www.empire.ca.

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 or other applicable legislation.

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

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

Signed at (City, Province)	Date (dd/mmm/yy)
Address of Claimant	
Signature of Claimant X	

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IMPORTANT INFORMATION FOR COMPLETING THIS FORM

Please note the following before completing this form:

- A claim form may not be required for Life claims under $75,000 with no minor beneficiary and no Accidental Death claim - please call us at the number below for the requirements.
- If there are multiple beneficiaries a Claimant's Statement must be completed for each beneficiary.
- The Attending Physician's Statement (page 3 of this form) is always required for all Life claims of $75,000 and over and for all Accidental Death Claims. It may be required for other Life claims upon request by Empire Life.
- In furnishing 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. **For an estate beneficiary** – Claimant's statement must be completed by the estate representative.

   Was a will left? ☐ yes ☐ no

   If a will was left, is it being probated? ☐ yes ☐ no

   a) If the deceased left a will – The Claimant's 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.

   b) If the deceased did not leave a will – The Claimant's 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's Statement completed by the heir(s).

2. **If the beneficiary is a minor** – The Claimant's 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's 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).

4. **Social Insurance Number of the beneficiary** – This information should be filled in as it is required for the reporting of any taxable interest paid to the beneficiary. If the estate of the deceased is the Claimant, the deceased's Social Insurance Number (SIN) should be filled in. If the beneficiary does not have a Social Insurance Number please note this in Section 2 - Claimant's Statement.

Contact us at:

Telephone: 1 800 267-0215, **Fax:** 613 548-8402 or toll free at 1 855 430-9455 or **Email:** grouplifeanddisability@empire.ca

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ATTENDING PHYSICIAN'S STATEMENT
GROUP LIFE AND ACCIDENTAL DEATH INSURANCE CLAIM

To be completed for all Life claims of $75,000 and over and for all Accidental Death claims.

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 The Empire Life Insurance Company (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)

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

Attending Physician's Statement - 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:		
I hereby certify that _____ (name of deceased) employed by _____ died on _____ (dd/mmm/yy).		
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.		
Signed at (City, Province)	Date (dd/mmm/yy)	
Name of Physician (please print)	Phone number	
Full address of Physician (please print)		
Signature of Physician X		

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