## 3 Claimant's statement

**If the claimant is a minor beneficiary, the form must be completed on behalf of the minor beneficiary by an appointed trustee or guardian of the child or child's property, in the absence of an appointed trustee.**

### Instructions to claimant

**Please indicate one of the situations below, and provide the required document(s).**

**Proceeds UNDER $300,000**

- ◯ Provide original or copy of Funeral Director's Statement of Death, **and** newspaper death report or obituary notice (if available)

  **OR**

- ◯ Attending Physician's Report (pages 5 and 6 of this form)

**Proceeds $300,000 and OVER**

- ◯ Original or copy of Provincial Death Certificate

  **OR**

- ◯ Attending Physician's Report (pages 5 and 6 of this form)

**Accidental Death**

- ◯ Attending Physician's or Coroner's Statement (pages 7 and 8 of this form)

**Accidental Dismemberment**

- ◯ Attending Physician's Statement (pages 9 and 10 of this form)

**Miscellaneous requirements**

**Payments to minor beneficiary**

- ◯ Original or copy of Court appointment of Guardianship of the Estate of the Minor

**Payments to estate**

- ◯ Original or copy of the Probated Will or Letters of Administration for proceeds over $50,000.00

**Beneficiary is deceased**

- ◯ Copy of deceased Beneficiary's Proof of Death

**Please submit this form and the required document(s) to the appropriate address:**

**For English Claims**
Manulife
PO BOX 400 STN PLACE-D'ARMES MONTREAL QC H2Y 3H1
Tel: 1-877-481-9169
Fax: 1-866-292-9050
Email: group_disability_claims@manulife.com

**For French Claims**
Manulife
PO BOX 400 STN PLACE-D'ARMES MONTREAL QC H2Y 3H1
Tel: 1-877-481-9169
Fax: 1-866-292-9050
Email: groupe_invalidite@manuvie.com

**If sending by courier**
Manulife
ATTN: GROUP LIFE CLAIMS
2000 MANSFIELD, SUITE 220
MONTREAL QC H3A 2Y8

Plan contract number _____ Plan member certificate number _____

Plan member name (first, middle initial, last) _____

**Please select the nature of the claim:**

- ◯ Death - complete this section with information about the deceased.
- ◯ Dismemberment - complete this section about the insured member/dependent who sustained the injury.

Name (first, middle initial, last) _____ Marital status ◯ Married ◯ Single

Sex _____ Date of birth (dd/mmm/yyyy) _____ Date of death/loss (dd/mmm/yyyy) _____

Address (number, street, apt) _____

City _____ Province _____ Postal code _____

If deceased/injured was a dependant child and attending school, name institution _____

At time of death/injury, was the dependent employed? ◯ Yes ◯ No If *yes*, indicate numbers of hours worked per week: _____

Please indicate cause of death or, if injury/death caused by an accident, please specify the date and the circumstances:

_____

_____

_____

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

Claimant's relationship to the deceased/injured _____ Claimant's date of birth (dd/mmm/yyyy) _____

Claimant's address (number, street, apt) _____

City _____ Province _____ Postal code _____

Claimant's primary phone number _____ Claimant's SIN _____

## 3 Claimant's statement (continued)

**To be completed in case of a death claim.**

Name of funeral home _____ Funeral home phone number _____

I claim in the capacity of: ◯ Beneficiary ◯ Executor ◯ Legatee ◯ Heir ◯ Other (please specify) _____

**By providing my personal email address, I am authorizing Manulife to use the address provided as an additional means of communication about my file. I acknowledge that correspondence by email may contain personal information including, but not limited to medical, employment and financial information. I understand that my personal information is being sent in a manner that is not yet guaranteed as a secure means of communication.**

Claimant's email address _____

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

## 4 Direct deposit authorization

**If the plan sponsor allows direct deposit, and if benefits are approved, please complete this section to consent to receiving benefits by direct deposit.**

- ◯ **If depositing to a chequing account, please sign the authorization, and attach a copy of a void cheque in the area below.**
- ◯ **If depositing into a savings account, please complete the required information, sign the authorization and provide a copy of your banking statement.**
- ◯ **If the deposit is being made to an Estate, please complete the required information, sign the authorization and provide a bank statement/void cheque confirming the Estate account. Otherwise, proceeds will be paid by cheque.**

Name of financial institution _____

Address of financial institution (number, street, suite) _____

City _____ Province _____ Postal code _____

Type of account: ◯ **Chequing** ◯ **Savings** ◯ **Estate**

Branch or transit number (5 digits) _____ Institution number (3 digits) _____

Bank account number (maximum 12 digits) _____

**I hereby authorize** Manulife to deposit, until further notice, payment due to me from the above policy, into my bank account. I agree that Manulife will have no further liability with respect to any payments made in accordance with this authorization, and may at any time discontinue payment as requested herein and require my personal endorsement. **I, for myself, my heirs, my executors, administrators, and assigns do hereby consent and agree** that any sums of money so paid to the bank after my death shall be refunded to Manulife for distribution to the person or persons, if any, entitled thereto under the terms of the policy. For Group Life and Health policies, **I authorize** the use of my Social Insurance Number (SIN) when applicable for the purposes of my request for Direct Bank Deposit. **I authorize** the use of my SIN for the purposes of identification and administration, if my SIN is used as my certificate number. The above request and authorization apply to any other account in this financial institution or any other financial institution subsequently named by me.

Claimant's signature _____ Date (dd/mmm/yyyy) _____

Claimant's name (please print) _____

**If providing a copy of a void cheque, please place it here.**

## 5 Claimant's certification and authorization for all death claims

**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/injured (first, middle initial, last) _____

**I understand:**

- that Manulife will investigate this claim and may require information related to the deceased's health, employment, police investigations, autopsy, toxicology or coroners' reports.

**I authorize:**

- Manulife, its service providers, Manulife's reinsurers and its service providers, and any person or organization who has personal 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 collect, use, maintain and disclose information for the purposes of group plan administration and audits as well as the assessment and investigation of this claim.
- the use of my Social Insurance Number (SIN) for the purpose of tax reporting.

**I confirm:**

- that a photocopy or electronic version of this authorization shall be as valid as the original.
- that I understand that more specific details regarding how and why Manulife collects, uses, maintains, and discloses personal information can be found in Manulife's Privacy Policy, available at www.manulife.ca/corporate/privacy-policy/canadian-division-privacy-policy.html or through the Plan Sponsor.

**I acknowledge:**

- that any personal information provided to or collected by Manulife in accordance with this authorization will be kept in a group life, health, or disability benefits file. Access to or disclosure of any personal information will be limited to Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs; persons to whom I have granted access or authorized disclosure; and persons authorized by law.
- I have the right to request access to the personal information in the file, and, where appropriate, to have any inaccurate information corrected.
- I may revoke my authorizations in this section at any time by sending a written instruction to Manulife.

Claimant's signature _____ Date (dd/mmm/yyyy) _____

Claimant's name (please print) _____

**Important - Please see instructions on Page 2 (Instructions to claimant) regarding the required document(s) prior to proceeding to pages 5-10.**