2 Claimant's statement for death of a plan member

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

Plan numbers of other Manulife Financial plans for which a claim is being made

Claimant's mailing address (number, street)

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

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)