Equitable Life of Canada®

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GROUP LIFE CLAIM - CLAIMANT'S STATEMENT

Deceased's Name (in full) _____ Group Policy No: _____

Province or State of Domicile _____ Place of Death _____

Cause of Death _____

Date of Death _____ Date and Place of Birth _____

Names and addresses of all Physicians who attended the deceased in the past five years.

Name	Address	Date	Reason

Names and locations of all Hospitals or Institutions where the deceased was treated in the past five years.

Hospital or Institution	City or Town	Date

Your Name (please print) _____ S.I.N. / Tax Ident. (IRS) No. _____

Your Address (in full) _____ Postal or Zip Code _____

Are you 18 years of age or over? ☐ Yes ☐ No If not, give date of birth (day, month, year) _____

In what capacity or by what do you claim the insurance? (e.g. Named Beneficiary, Executor)? _____

Relationship to Deceased _____

AUTHORIZATION & ACKNOWLEDGEMENT:

I certify that the information given on this form is true, correct and complete.

For the purposes of underwriting, administration, claims processing and adjudication with respect to the Group Policy and any supplementary forms/documents, I authorize The Equitable Life Insurance Company of Canada ("Equitable"), its employees, representatives and service providers to use my personal information, and exchange such personal information with reinsurers, insurers, investigative agencies, health care providers and facilities, and any other person or party whom I authorize.

For the above purposes, I authorize any physician, practitioner or other health care provider, hospital, clinic or other medical facility, pharmacy, insurer, employer (past and present), WSIB/Workers Compensation plan, medical or benefit payment plan, service provider, and any other institution, person or party that has any record or knowledge of my health, to give to Equitable full particulars of such information, including any prior medical history and benefits.

I authorize and direct The Equitable Life Insurance Company of Canada to deduct from the life insurance proceeds payable to me any overpayment of disability benefits paid to the deceased by Equitable Life.

A photocopy of this acknowledgement shall be as valid as the original.

Dated at _____ this _____ day of _____.

Witness _____ Signature of Claimant(s) _____

Signature of Claimant(s _____

In furnishing this or other claims forms to the claimant the Company does not admit to any liability or waive any of its rights.

INSTRUCTIONS

Please feel free to ask your Group Plan Administrator or the Group Life and Disability benefit department at Equitable Life for information or assistance in completing the Claimant's Statement. We will be glad to do anything we can to help you.

COMPLETING THE CLAIMANT'S STATEMENT

1. If the policy is payable to a named beneficiary or beneficiaries:

   a) This statement should be completed by the named beneficiary, unless a minor. If there is more than one beneficiary, all should join in completing the statement, or, if desired, separate forms will be supplied.

   b) If any named beneficiary is a minor, this statement should be completed, on behalf of the minor beneficiary, by the guardian or other person authorized by law to deal with the minor's property. A certified copy of the Letters of Guardianship must be submitted.

   c) If any named beneficiary is deceased, proof of death of such beneficiary must be furnished.

2. If the Policy is payable to the estate of the deceased:

   The cheque will be made payable to "The Estate".

3. Claimant's Social Insurance No./Tax Ident. (IRS) No.:

   This information should be filled in by the claimant as it may be required for the reporting of any taxable income paid to the claimant. If the claimant has never been assigned a number, insert "No Number". If the estate of the deceased is the claimant, the deceased's Social Insurance No./Tax Ident. (IRS) No. should be filled in.