Manulife Financial

# Life Claim

**Please see instructions on page 2 for completing this form.**

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## Instructions for completion & requirements

◯ **PLAN MEMBER LIFE CLAIM** *(please print all answers)*

*Complete page 3, 4 & 5 of this form*
- Plan administrator complete and sign section 1,
- Claimant complete and sign sections 2, 3 & 4.

***Please check for the following requirements:***

**Proceeds UNDER $300,000**
- ◯ Original, certified or notarized copy of Funeral Director's Statement of Death, and newspaper death report or obituary notice (if available)

  **OR**
- ◯ Original, certified or notarized copy of Provincial Death Certificate

  **OR**
- ◯ Attending Physician's Statement (page 9 of this form)

**Proceeds $300,000 and OVER**
- ◯ Original, certified or notarized copy of Provincial Death Certificate

  **OR**
- ◯ Attending Physician's Statement (page 9 of this form)

**Accidental Death**
- ◯ Attending Physician's or Coroner's Statement (page 11 of this form)

**Plan sponsor administered group** ***(if you maintain the eligibility records for the plan member, please complete the section for plan sponsor administered groups)***
- ◯ ORIGINAL of the Plan Member Enrolment form

◯ **DEPENDANT LIFE CLAIM** *(please print all answers)*

*Complete page 6, 7 & 8 of this form*
- Plan administrator complete and sign section 1,
- Claimant complete and sign sections 2, 3 & 4.

***Please check for the following requirements:***

**Proceeds UNDER $300,000**
- ◯ Original, certified or notarized copy of Funeral Director's Statement of Death, and newspaper death report or obituary notice (if available)

  **OR**
- ◯ Original, certified or notarized copy of Provincial Death Certificate

  **OR**
- ◯ Attending Physician's Statement (page 9 of this form)

**Proceeds $300,000 and OVER**
- ◯ Original, certified or notarized copy of Provincial Death Certificate

  **OR**
- ◯ Attending Physician's Statement (page 9 of this form)

**Accidental Death** (if applicable)
- ◯ Attending Physician's or Coroner's Statement (page 11 of this form)

**Plan sponsor administered group** ***(if you maintain the eligibility records for the plan member, please complete the section for plan sponsor administered groups)***
- ◯ COPY of the Plan Member Enrolment form

## Miscellaneous requirements

**Payments to minor beneficiary**
- ◯ ORIGINAL or NOTARIZED copy of Court appointment of Guardianship of the Estate of the Minor

**Payments to estate**
- ◯ ORIGINAL or NOTARIZED copy of the Probated Will or Letters of Administration for proceeds $50,000 and over.

**Beneficiary has died before the plan member**
- ◯ ORIGINAL, CERTIFIED or NOTARIZED copy of deceased Beneficiary's Proof of Death

**Please submit this claim to the appropriate address:**

Manulife Financial
Halifax Group Life Claims Office
PO BOX 1030 STN CENTRAL
HALIFAX NS B3J 2X5
Tel: 1-866-447-4517
(902) 453-4300
Fax: 1-866-292-9050
(902) 429-7292

Manulife Financial
Montreal Group Life Claims Office
PO BOX 395 STN PLACE-D'ARMES
MONTREAL QC H2Y 3H1
Tel: 1-866-236-6313
(514)288-6268
Fax: 1-888-488-6738
(514)286-6738

Manulife Financial

# Group Benefits
# Plan Member Claim
## Life and Accidental Death (if applicable)

***For dependant death claim use pages 6, 7 & 8. Please print clearly***

### 1 Plan administrator's statement for death of plan member

| Plan contract number(s) | Account/Division number | Class | Union local | Plan member certificate number |
|---|---|---|---|---|
| | | | | |

| Plan sponsor's name | Deceased plan member's job title |
|---|---|
| | |

| Deceased plan member's name (last, first, middle initial) | Date of birth (dd/mmm/yyyy) |
|---|---|
| | |

| Date of employment (dd/mmm/yyyy) | Beneficiary's name (last, first, middle initial) | Relationship |
|---|---|---|
| | | |

Check applicable benefit(s) and specify face amounts

◯ Basic Life $ _____ ◯ Paid Up Life $ _____ ◯ Basic Accidental Death $ _____

◯ Optional Life $ _____ ◯ Permanent Paid Up Life $ _____ ◯ Optional Accidental Death $ _____

| Date last worked (dd/mmm/yyyy) | Salary as of last day worked | | | |
|---|---|---|---|---|
| | $ _____ | ◯ Annually | ◯ Semi-monthly | ◯ Weekly |
| | | ◯ Monthly | ◯ Bi-weekly | ◯ Hourly |

| Regular number of hrs. worked/week | Salary effective date (dd/mmm/yyyy) | Date of death (dd/mmm/yyyy) | Date of termination (if applicable) (dd/mmm/yyyy) |
|---|---|---|---|
| | | | |

**Did the plan member contribute part of the premium payment?** ◯ Yes ◯ No

If death occurred after date last actively at work, please indicate status:

◯ Retired ◯ Temporary layoff ◯ Dismissed

◯ Disabled ◯ Leave of absence ◯ Resigned

**If plan member was disabled prior to death, was any claim for disability benefits filed during this period?**

◯ Yes ◯ No If "Yes", please provide claim number and name of carrier

| Claim number | Name of carrier |
|---|---|
| | |

**Was this death accidental?** ◯ Yes ◯ No

If "Yes", please have the Attending Physician's or Coroner's Statement (page 11) completed and submit with this claim.

Date of accident (dd/mmm/yyyy)

**Did the accident occur while plan member was working?**

◯ Yes ◯ No If "Yes", please give location and address of accident.

| Location of accident | Address of accident |
|---|---|
| | |

**For Optional Life only - Was plan member insured at non-smoker rates?**

◯ Yes ◯ No if "Yes", attach copy of declaration

**For plan sponsor administered groups only:**

*If you maintain the eligibility records for the plan member please fill out this section and submit **ORIGINAL** enrolment form for this plan member.*

| Most recent effective date of plan member's coverage (dd/mmm/yyyy) | Original effective date of plan member's coverage (dd/mmm/yyyy) | Date to which premiums were paid (dd/mmm/yyyy) |
|---|---|---|
| | | |

### Plan administrator's declaration

**I certify** that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. The information in this statement will be kept in a Group Benefits life, health, or disability file with Manulife Financial and might be accessible by the claimant or third parties to whom access has been granted or those authorized by law. By providing the information **I consent** to such unedited release of any information contained herein.

| Authorized signature | Date signed (dd/mmm/yyyy) | Area code and phone number |
|---|---|---|
| ✘ | | ( ) |

| Mailing address (number, street) | City | Province | Postal code |
|---|---|---|---|
| | | | |

Manulife Financial

## 2 Claimant's statement for death of a plan member

| Relationship to deceased plan member | Plan numbers of other Manulife Financial plans for which a claim is being made |
|---|---|
| | |

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.

## 3 Settlement account (Manulife Bank Safe Access Account)

Manulife Financial is pleased to offer a unique settlement option for insurance policy proceeds. Qualifying beneficiaries may have their insurance policy proceeds deposited directly into a high-interest chequing account (called the Safe Access Account) with our affiliate company, Manulife Bank of Canada ("Manulife Bank"). This account provides you with easy access to your funds with free cheque writing and no monthly maintenance fees.

**Eligibility requirements**

This payment option is not available:

- If total insurance proceeds from a Manulife group policy are less than $10,000.
- To minors, courts, trusts, estates, corporations, partnerships or other entities.
- If the claimant does not have a Social Insurance Number.
- If the claimant is not a resident of Canada.
- For some insurance products or Group Benefits plans.

Any claims or claimants that are not eligible for this form of payment or indicate that they do not want a Safe Access Account will be paid their proceeds by cheque. If you need assistance, please contact the appropriate Group Benefits Life Claims Office:

Halifax (902) 453-4300 or 1-866-447-4517
Montreal (514) 288-6268 or 1-866-236-6313

Manulife Financial

## 4 Claimant's personal information

| Claimant's name (last, first, middle initial) | Claimant's phone number ( ) |
|---|---|
| | |

| Claimant's mailing address (number, street) | City | Province | Postal code |
|---|---|---|---|
| | | | |

| Claimant's date of birth (dd/mmm/yyyy) | Claimant's Social Insurance Number |
|---|---|
| | |

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

**I certify** that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. **I agree** that my claim may be denied as a result of my providing false, incomplete, or misleading information. **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 ("Manulife") and its reinsurer will investigate this claim and may require information related to the deceased's health, employment, police investigations, autopsy or coroners inquest reports (collectively referred to in this authorization as "Information"). **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, its reinsurers and its claims service providers for the purpose of benefits plan administration, investigation and management of this claim ("Purposes"). **I authorize** Manulife, its reinsurers and/or claim service providers to collect, use, maintain and disclose to the persons or organizations listed above and/or each other any Information needed for the Purposes. **I authorize** the use of my Social Insurance Number for tax reporting. **I agree** that a photocopy or electronic version of this authorization shall be as valid as the original.

**I authorize** Manulife to share necessary information regarding me or my claim with Manulife Bank, for the purpose of opening a Safe Access Account ("SAA"), if I am eligible for such an account.

**Manulife Bank Safe Access Account Terms and Conditions**

If I am eligible for an SAA, **I authorize** Manulife Bank to obtain, verify, give, share and exchange personal information about me, now and in the future, with any individuals, financial institutions, business corporations or other parties with whom I have, or propose to have, financial or personal dealings, or who hold information about such dealings, such as credit bureaus. My personal information will be used for the purpose of confirming my identity and the accuracy of the information I provide. Manulife Bank may collect information with this consent for the purposes of administering and maintaining my financial records and as may be otherwise permitted or required by law. **I authorize** any person that Manulife Bank contacts under this authorization to provide such information about me. **I authorize** Manulife Bank to record my telephone conversations for the administration of my SAA and to maintain quality service levels. If I do not wish that my telephone conversations be recorded, **I agree** only to communicate with Manulife Bank in writing and request that any response by Manulife Bank be in writing as well. **I understand** that information relating to Manulife Bank's privacy policy is available at www.manulifebank.ca or by calling 1-877-765-2265.

By signing this form, **I agree and acknowledge** that, if I meet the eligibility requirements for the SAA and if I have not made alternative payment arrangements:

- An SAA will be opened for me and my insurance claim proceeds will be deposited to this account;
- Manulife Bank will provide me with the following documents:
  (a) an SAA Operating Agreement ("Operating Agreement") which will set out the terms and conditions for the operation of the SAA;
  (b) a brochure that sets out the fees and other charges applicable to my SAA (the "Brochure");
- **I agree** to be bound by the Operating Agreement and the fees set out in the Brochure;
- **I agree** to provide my Social Insurance Number as it is required for tax reporting; and
- **I understand** that Manulife Bank may change its interest rates from time to time and interest rate changes will be posted at www.manulifebank.ca or by calling 1-877-765-2265.

**I understand that if I do not consent to the use of my personal information as outlined in the Manulife Bank Safe Access Account Terms and Conditions, I may mark the box below to arrange to receive the proceeds by cheque.**

◯ **I wish to receive the proceeds by cheque.**

**I understand** 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 my 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; and persons authorized by law.

**I understand** that Manulife's privacy policy is available at www.manulife.ca or upon request. **I understand** that 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) |
|---|---|
| | |

Manulife Financial

# Group Benefits Dependant Claim

## Life and Accidental Death (if applicable)

***For plan member death claim use pages 3, 4 & 5. Please print clearly.***

### 1 Plan administrator's statement for death of dependant – plan member details

| Plan contract number(s) | Account/Division number | Class | Union local | Plan member certificate number |
|---|---|---|---|---|
| | | | | |

| Plan sponsor's name | Employer's name (if different from plan sponsor) |
|---|---|
| | |

| Plan member's name (last, first, middle initial) | Date of birth (dd/mmm/yyyy) |
|---|---|
| | |

| Plan member's mailing address (number, street) | City | Province | Postal code |
|---|---|---|---|
| | | | |

| Date of employment (dd/mmm/yyyy) | Job title |
|---|---|
| | |

Check applicable benefit(s) and specify face amounts

◯ Basic Life $ _____ ◯ Basic Accidental Death $ _____ ◯ Paid Up Life $ _____

◯ Optional Life $ _____ ◯ Optional Accidental Death $ _____

| Date last worked (dd/mmm/yyyy) | Salary as of last day worked | | | |
|---|---|---|---|---|
| | $ _____ | ◯ Annually | ◯ Semi-monthly | ◯ Weekly |
| | | ◯ Monthly | ◯ Bi-weekly | ◯ Hourly |

| Regular number of hrs. worked/week | Salary effective date (dd/mmm/yyyy) | Date of death (dd/mmm/yyyy) | Date of termination (if applicable) (dd/mmm/yyyy) |
|---|---|---|---|
| | | | |

If death occurred after date last actively at work, please indicate status:

◯ Retired ◯ Temporary layoff ◯ Dismissed

◯ Disabled ◯ Leave of absence ◯ Resigned

**If plan member was disabled prior to death, was any claim for disability benefits filed during this period?**

◯ Yes ◯ No If "Yes", please provide claim number and name of carrier

| Claim number | Name of carrier |
|---|---|
| | |

| Deceased dependant's name (last, first, middle initial) | Relationship to plan member |
|---|---|
| | |

**Was this death accidental?** ◯ Yes ◯ No

If "Yes", please have the Attending Physician's or Coroner's Statement (page 11) completed and submit with this claim.

Date of accident (dd/mmm/yyyy)

**Did the accident occur while dependant was working?**

◯ Yes ◯ No If "Yes", please give location and address of accident.

| Location of accident | Address of accident |
|---|---|
| | |

**For Optional Life only - If claim is for spouse, was dependant spouse insured at non-smoker rates?**

◯ Yes ◯ No if "Yes", attach copy of declaration

**For plan sponsor administered groups only:**

*If you maintain the eligibility records for the plan member please fill out this section and submit **ORIGINAL** enrolment form for this plan member.*

| Most recent effective date of plan member's coverage (dd/mmm/yyyy) | Original effective date of dependant's coverage (dd/mmm/yyyy) | Date to which premiums were paid (dd/mmm/yyyy) |
|---|---|---|
| | | |

### Plan administrator's declaration

**I certify** that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. The information in this statement will be kept in a Group Benefits life, health, or disability file with Manulife Financial and might be accessible by the claimant or third parties to whom access has been granted or those authorized by law. By providing the information **I consent** to such unedited release of any information contained herein.

| Authorized signature | Date signed (dd/mmm/yyyy) | Area code and phone number |
|---|---|---|
| ✘ | | ( ) |

| Mailing address (number, street) | City | Province | Postal code |
|---|---|---|---|
| | | | |

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## 2 Plan member's statement for death of a dependant

| Deceased dependant's address (number, street) | City | Province | Postal code |
|---|---|---|---|
| | | | |

| Deceased's date of birth (dd/mmm/yyyy) | Deceased's marital status | If deceased was a dependant child and attending school, name institution |
|---|---|---|
| | ◯ Married ◯ Single | |

| Cause of death | Date of death (dd/mmm/yyyy) |
|---|---|
| | |

If deceased died in hospital, please give date admitted (dd/mmm/yyyy)

**At time of death, was the dependant employed?**
◯ Yes ◯ No If "Yes," indicate number of hours worked — Number of hours per week

**Was he/she dependent on you for support?** ◯ Yes ◯ No

**Was the dependant confined to a hospital when coverage became effective?**
◯ Yes ◯ No If "Yes," indicate date discharged (dd/mmm/yyyy)

## 3 Settlement account (Manulife Bank Safe Access Account)

Manulife Financial is pleased to offer a unique settlement option for insurance policy proceeds. Qualifying beneficiaries may have their insurance policy proceeds deposited directly into a high-interest chequing account (called the Safe Access Account) with our affiliate company, Manulife Bank of Canada ("Manulife Bank"). This account provides you with easy access to your funds with free cheque writing and no monthly maintenance fees.

**Eligibility requirements**
This payment option is not available:
- If total insurance proceeds from a Manulife group policy are less than $10,000.
- To minors, courts, trusts, estates, corporations, partnerships or other entities.
- If the claimant does not have a Social Insurance Number.
- If the claimant is not a resident of Canada.
- For some insurance products or Group Benefits plans.

Any claims or claimants that are not eligible for this form of payment or indicate that they do not want a Safe Access Account will be paid their proceeds by cheque. If you need assistance, please contact the appropriate Group Benefits Life Claims Office:
Halifax (902) 453-4300 or 1-866-447-4517
Montreal (514) 288-6268 or 1-866-236-6313

Manulife Financial

## 4 Claimant's personal information

| Claimant's name (last, first, middle initial) | Claimant's phone number ( ) |
|---|---|
| | |

| Claimant's mailing address (number, street) | City | Province | Postal code |
|---|---|---|---|
| | | | |

| Claimant's date of birth (dd/mmm/yyyy) | Claimant's Social Insurance Number |
|---|---|
| | |

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

**I certify** that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. **I agree** that my claim may be denied as a result of my providing false, incomplete, or misleading information. **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 ("Manulife") and its reinsurer will investigate this claim and may require information related to the deceased's health, employment, police investigations, autopsy or coroners inquest reports (collectively referred to in this authorization as "Information"). **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, its reinsurers and its claims service providers for the purpose of benefits plan administration, investigation and management of this claim ("Purposes"). **I authorize** Manulife, its reinsurers and/or claim service providers to collect, use, maintain and disclose to the persons or organizations listed above and/or each other any Information needed for the Purposes. **I authorize** the use of my Social Insurance Number for tax reporting. **I agree** that a photocopy or electronic version of this authorization shall be as valid as the original.

**I authorize** Manulife to share necessary information regarding me or my claim with Manulife Bank, for the purpose of opening a Safe Access Account ("SAA"), if I am eligible for such an account.

**Manulife Bank Safe Access Account Terms and Conditions**

If I am eligible for an SAA, **I authorize** Manulife Bank to obtain, verify, give, share and exchange personal information about me, now and in the future, with any individuals, financial institutions, business corporations or other parties with whom I have, or propose to have, financial or personal dealings, or who hold information about such dealings, such as credit bureaus. My personal information will be used for the purpose of confirming my identity and the accuracy of the information I provide. Manulife Bank may collect information with this consent for the purposes of administering and maintaining my financial records and as may be otherwise permitted or required by law. **I authorize** any person that Manulife Bank contacts under this authorization to provide such information about me. **I authorize** Manulife Bank to record my telephone conversations for the administration of my SAA and to maintain quality service levels. If I do not wish that my telephone conversations be recorded, **I agree** only to communicate with Manulife Bank in writing and request that any response by Manulife Bank be in writing as well. **I understand** that information relating to Manulife Bank's privacy policy is available at www.manulifebank.ca or by calling 1-877-765-2265.

By signing this form, **I agree and acknowledge** that, if I meet the eligibility requirements for the SAA and if I have not made alternative payment arrangements:

- An SAA will be opened for me and my insurance claim proceeds will be deposited to this account;
- Manulife Bank will provide me with the following documents:
  (a) an SAA Operating Agreement ("Operating Agreement") which will set out the terms and conditions for the operation of the SAA;
  (b) a brochure that sets out the fees and other charges applicable to my SAA (the "Brochure");
- **I agree** to be bound by the Operating Agreement and the fees set out in the Brochure;
- **I agree** to provide my Social Insurance Number as it is required for tax reporting; and
- **I understand** that Manulife Bank may change its interest rates from time to time and interest rate changes will be posted at www.manulifebank.ca or by calling 1-877-765-2265.

**I understand that if I do not consent to the use of my personal information as outlined in the Manulife Bank Safe Access Account Terms and Conditions, I may mark the box below to arrange to receive the proceeds by cheque.**

◯ **I wish to receive the proceeds by cheque.**

**I understand** 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 my 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; and persons authorized by law.

**I understand** that Manulife's privacy policy is available at www.manulife.ca or upon request. **I understand** that 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) |
|---|---|
| | |

Manulife Financial

# Group Benefits
# Attending Physician's Report

***If there is a charge for the completion of this form, payment is the responsibility of the claimant. Please print clearly.***

**Completed reports should be returned to:**

| Plan contract number(s) | Account/Division number | Union local | Plan member certificate number |
|---|---|---|---|
| | | | |

Plan administrator's name (last, first, middle initial)

| Plan administrator's mailing address (number, street) | City | Province | Postal code |
|---|---|---|---|
| | | | |

The Medical Certification follows the recommendation of the World Health Organization. It has been accepted in Canada and the United States. In the interest of accurate vital statistics, please conform to the current International List of Causes of Death. When complete, please return this form to the plan administrator at the address shown above.

**Physician's report**

| Deceased's name (last, first, middle initial) | Place of death | Date of death (dd/mmm/yyyy) |
|---|---|---|
| | | |

| If death occurred in an institution or hospital, please give name | Age at death |
|---|---|
| | |

| Residence address at death (number, street) | City | Province | Postal code |
|---|---|---|---|
| | | | |

**Cause of death**
*Enter only one cause for each of a, b and c.*

**Disease and condition directly leading to death:** (This does not mean the mode of dying such as heart failure, asthenia, etc. It means the disease, injury or complication which caused the death).

| (a) | **Interval between onset and death** (a) |
|---|---|
| | |

**Antecedent causes.** (Morbid conditions, if any, giving rise to the above cause (a) stating underlying causes last).

| Due to (b) | **Interval between onset and death** (b) |
|---|---|
| | |
| Due to (c) | (c) |
| | |

**To your knowledge, did the deceased ever smoke?** ◯ Yes ◯ No ◯ I don't know If "Yes", how many years? Number of years

Date of first attendance in last illness (dd/mmm/yyyy)

Date of last attendance in last illness (dd/mmm/yyyy)

If death was due to accident, suicide or homicide, specify which and describe briefly.

**Was an inquest held?** ◯ Yes ◯ No **Was an autopsy performed?** ◯ Yes ◯ No

If "Yes," to either of the above, by whom and what findings?

Have you treated or advised the deceased during the last five years, prior to last illness? ◯ Yes ◯ No

Did the deceased, to your knowledge, receive treatment during the last five years from any other physician, or in any hospital or institution? ◯ Yes ◯ No

***If "Yes," to either of the above, please provide the following information.***

| Name | Address | Nature of illness/injury | Approximate dates |
|---|---|---|---|
| | | | (dd/mmm/yyyy) |
| | | | (dd/mmm/yyyy) |

***Please complete page 10 of this form.***

## Attending physician's personal information

| Attending physician's full name | | Specialty |
|---|---|---|
| Address (number, street) | City | Province / Postal code |
| Area code and phone number ( ) | Area code and fax number ( ) | |

## Attending physician's signature

**I certify** that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. The information in this statement will be kept in a Group Benefits life, health, or disability file with Manulife Financial and might be accessible by the claimant or third parties to whom access has been granted or those authorized by law. By providing the information **I consent** to such unedited release of any information contained herein.

| Attending physician's signature | Date signed (dd/mmm/yyyy) |
|---|---|

Manulife Financial

# Group Benefits
# Attending Physician's or Coroner's Statement for Accidental Death

***If there is a charge for the completion of this form, payment is the responsibility of the claimant. Please print clearly.***

**Completed reports should be returned to:**

| Plan contract number(s) | Account/Division number | Union local | Plan member certificate number |
|---|---|---|---|
| | | | |

Plan administrator's name (last, first, middle initial)

| Plan administrator's mailing address (number, street) | City | Province | Postal code |
|---|---|---|---|
| | | | |

**Attending physician's or coroner's statement for accidental death**

| Deceased's name (last, first, middle initial) | Date of injury (dd/mmm/yyyy) | Date of death (dd/mmm/yyyy) |
|---|---|---|
| | | |

**What was the precise nature and extent of the injury?**

**What was the primary or immediate cause of death?**

**Was the deceased ever treated for a similar condition?**

◯ Yes ◯ No If "Yes," where and by whom?

**Were there any contributing or remote causes of death?**

◯ Yes ◯ No If "Yes," what were they?

**Was the injury, described above, by itself and independent of all other causes, sufficient to cause death?**

◯ Yes ◯ No If "No," please explain fully.

**At the time of the injury, was the deceased under the influence of alcohol or narcotic drugs?**

◯ Yes ◯ No If "Yes," please show blood alcohol content and/or type of drug.

| Blood alcohol content | Type of drug |
|---|---|
| | |

Was an autopsy performed? ◯ Yes ◯ No

***Please complete page 12 of this form.***

## Attending physician's or coroner's personal information

| Attending physician's or coroner's full name | | Specialty | |
|---|---|---|---|
| Address (number, street) | City | Province | Postal code |
| Area code and phone number<br>( ) | Area code and fax number<br>( ) | | |

## Attending physician's or coroner's signature

**I certify** that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. The information in this statement will be kept in a Group Benefits life, health, or disability file with Manulife Financial and might be accessible by the claimant or third parties to whom access has been granted or those authorized by law. By providing the information **I consent** to such unedited release of any information contained herein.

| Attending physician's or coroner's signature | Date signed (dd/mmm/yyyy) |
|---|---|