Manulife Financial

**Group Survivor**

***Note: Copies of the following documents must accompany this form:***

***- birth certificates of the plan member, spouse and all eligible children***

***- marriage certificate or affidavit of co-habitation of spouse***

***- proof of school attendance of children if attendance at school is required by the group contract.***

## SECTION 1 - PLAN ADMINISTRATOR'S STATEMENT

| PLAN NUMBER | DIVISION NO. | ACCOUNT NO. | UNION LOCAL | CERTIFICATE NUMBER(S) | PLAN SPONSOR NAME |
|---|---|---|---|---|---|
| G IMPORTANT: | THIS | INFORMATION | | MUST BE | PROVIDED |

1. ADDRESS OF PLAN SPONSOR — Apt./Street Number — STREET — CITY — PROVINCE — POSTAL CODE — TELEPHONE NUMBER

2. NAME OF PLAN MEMBER (last name, first name, middle initial)

3. ADDRESS OF PLAN MEMBER — Apt./Street Number — STREET — CITY — PROVINCE — POSTAL CODE

4. DATE OF BIRTH — DAY / MONTH / YEAR

5. DATE OF EMPLOYMENT — DAY / MONTH / YEAR

6. ACTUAL DATE LAST WORKED — DAY / MONTH / YEAR

7. REASON FOR TERMININATION (if applicable)

8. CURRENT SALARY (exclude commissions, bonus and overtime)

$ ☐ HOURLY ☐ SALARIED

REGULAR NUMBER OF HOURS WORKED PER WEEK

IF COMMISSIONS, BONUSES OR OVERTIME ARE INCLUDED IN SALARY FOR INSURANCE PURPOSES, PROVIDE

YEAR TO DATE → $

PREVIOUS THREE CALENDAR YEARS → $ (dd/mmm/yyyy) $ (dd/mmm/yyyy) $ (dd/mmm/yyyy)

9. PLAN MEMBER WAS:

☐ PERMANENT ☐ FULL TIME ☐ RETIRED ON (dd/mmm/yyyy)

☐ TEMPORARY ☐ PART TIME

10. OCCUPATION

11. DATE OF DEATH — DAY / MONTH / YEAR

13. CAUSE OF DEATH

14. EFFECTIVE DATE OF INSURANCE — DAY / MONTH / YEAR

15. MONTHLY BENEFIT AMOUNT

$

DATE OF LAST CHANGE — DAY / MONTH / YEAR

16. MONTHLY BENEFIT

☐ INCREASE ☐ DECREASE

## PLAN ADMINISTRATOR'S CERTIFICATION AND AUTHORIZATION FOR ALL DEATH CLAIMS

NOTICE: By completing this Plan Administrator's statement, information contained herein will become part of a GROUP LIFE, HEALTH AND DISABILITY file which might be accessible by third parties to whom access has been granted or those authorized by law. By signing the statement you consent to such unedited release of any information contained therein. An unsigned statement has no validity and cannot be considered for evaluation of any claim.

| SIGNATURE OF PLAN ADMINISTRATOR | DATE SIGNED |
|---|---|
| | |

## SECTION 2 - CLAIMANT'S STATEMENT

### PART A - STATEMENT OF SURVIVING SPOUSE

1. NAME OF SURVIVING SPOUSE(last name, first name, middle initial)

2. ADDRESS OF SURVIVING SPOUSE Apt./Street Number STREET CITY PROVINCE | POSTAL CODE | TELEPHONE NUMBER

☐ SAME AS PLAN MEMBER

3. DATE OF BIRTH DAY MONTH YEAR

4. SOCIAL INSURANCE NUMBER

5. WERE YOU LIVING APART FROM THE PLAN MEMBER AT THE TIME OF DEATH? ☐ YES ☐ NO

IF YES TO QUESTION 5, UNDER WHAT CIRCUMSTANCES DID THE SEPARATION EXIST?

I certify that the statements provided by me are true and accurate to the best of my knowledge and belief.
I the undersigned, hereby make claim for the Group Survivor Insurance on the deceased _____ (name of deceased).
I understand that it may be necessary for Manulife Financial to investigate this claim. I authorize any physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medical or medically-related facility, corporation, organization, institution, association or person who attended the deceased or in which the deceased may have been a patient at any time during the five years preceding his/her death to release and exchange information or records requested by Manulife Financial to establish or review the validity of this claim.
I understand that this information will be maintained in a GROUP LIFE, HEALTH AND DISABILITY file with Manulife Financial.
I understand that persons, with satisfactory identification and proof of entitlement, will have the right to request access and, if necessary, rectify such personal information. I understand that Manulife employees or representatives in the performance of their duties, people to whom access has been granted or those authorized by law, will have access to information maintained on file.
I authorize the use of my Social Insurance Number for the purpose of tax reporting and for identification and administration of the Group Benefits.
I agree that a photocopy of this authorization shall be as valid as the original.

| SIGNATURE OF SPOUSE | DATE SIGNED |
|---|---|
| | |

### PART B - STATEMENT OF CLAIMANT FOR ELIGIBLE CHILDREN

***To be completed by the surviving spouse, or if there is no spouse, by the guardian or other claimant on behalf of the children.***

| NAME OF CHILDREN | COMPLETE ADDRESS | DATE OF BIRTH | ATTENDING SCHOOL YES | ATTENDING SCHOOL NO | IF YES, NAME AND ADDRESS OF SCHOOL |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

RELATIONSHIP OF CLAIMANT TO ELIGIBLE CHILDREN (*If Guardian or Other, provide your relationship to children and attach legal proof)*

☐ MOTHER ☐ FATHER ☐ GUARDIAN ☐ OTHER

FULL NAME AND ADDRESS OF CLAIMANT IF OTHER THAN SURVIVING SPOUSE

### CLAIMANT'S CERTIFICATION AND AUTHORIZATION FOR ALL DEATH CLAIMS

I hereby certify that the children listed above are the unmarried children of the Plan Member.
I certify that the statements provided by me are true and accurate to the best of my knowledge and belief.
I, the undersigned, hereby make claim for the Group Survivor Insurance on the deceased _____ (name of deceased).
I understand that it may be necessary for Manulife Financial to investigate this claim. I authorize any physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medical or medically-related facility, corporation, organization, institution, association or person who attended the deceased or in which the deceased may have been a patient at any time during the five years preceding his/her death to release and exchange information or records requested by Manulife Financial to establish or review the validity of this claim.
I understand that this information will be maintained in a GROUP LIFE, HEALTH AND DISABILITY file with Manulife Financial.
I understand that persons, with satisfactory identification and proof of entitlement, will have the right to request access and, if necessary, rectify such personal information. I understand that Manulife employees or representatives in the performance of their duties, people to whom access has been granted or those authorized by law, will have access to information maintained on file.
I authorize the use of my Social Insurance Number for the purpose of tax reporting and for identification and administration of the Group Benefits.
I agree that a photocopy of this authorization shall be as valid as the original.

| SIGNATURE OF CLAIMANT | DATE SIGNED | NAME OF CLAIMANT (please print) |
|---|---|---|
| | | |



GL1863E (0296) Formerly GC3024M and GC3029M