THE Great-West Life ASSURANCE COMPANY

Group Life Benefit Claim for Accidental Dismemberment or Specific Loss

PART 1 EMPLOYER'S OR ADMINISTRATOR'S STATEMENT

Name of Employee: _____

Address: _____

Group Policy No.: _____ Certificate No.: _____ Division No.: _____

Total amount of insurance coverage: $_____ Date of Birth: _____

Amount of Accidental Dismemberment or Loss Benefit: $_____ Date last reported for work prior to accident: _____

Salary or wages as of date last reported for work: $ _____ Has the employee returned to work? ☐ Yes ☐ No

If reason for leaving was other than the accident please give details. _____

_____

_____

Date of employment: _____ Name of Group: _____
EMPLOYER OR ASSOCIATION

Date _____ Year_____ By _____
SIGNATURE AND OFFICIAL TITLE

PART 2 CLAIMANT'S STATEMENT

Date of Accident:_____ Did the accident take place in the course of employment?* ☐ Yes ☐ No

Briefly describe how the accident occurred: _____

_____

_____

_____

Name of hospital if you were confined: _____

Dates of hospitalization: _____

Name of Attending Physician: _____

Physician's Address: _____
STREET CITY PROVINCE POSTAL CODE

Date of first treatment: _____

* If yes, please provide your accident report.

In what capacity or by what title do you claim this insurance money? _____

Are you over the age of 18?_____ If not, what is your date of birth? _____

Are you legally entitled to receive the whole of the monies payable under this policy, and to give the company a valid discharge therefor? _____

Are benefits to be released in a lump sum? ☐ Yes ☐ No

If No, an agent will call to discuss your options at your convenience.

PLEASE NOTE ADDITIONAL INFORMATION ON THE REVERSE SIDE OF THIS FORM

AUTHORIZATIONS AND DECLARATIONS

Protecting your Personal Information

At **The Great-West Life Assurance Company (Great-West Life)**, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the group benefits plan. This includes investigating and assessing claims, and creating and maintaining records concerning our relationship. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information" on this form.

I authorize Great-West Life, any healthcare provider, the deceased's plan administrator, any insurance or reinsurance company, administrators of government benefits or other benefits programs, government and law enforcement agencies, any person having knowledge about the deceased's health or about the circumstances of the deceased's death, other organizations, or service providers working with Great-West Life or the above to exchange personal information when relevant and necessary to investigate and assess this claim and to administer the group benefits plan.

I have provided the information on this form in order to obtain payment of Group Life proceeds payable to me (in a personal capacity or on behalf of a beneficiary) and I hereby declare that I am legally entitled to receive all or a share of the proceeds payable under the group benefits plan. I certify that by making payment to me, Great-West Life has met its obligation to me. I further declare that the answers given by me are, to the best of knowledge and belief, true and full and I have withheld no material facts from Great-West Life.

I confirm that a photocopy or electronic copy of this authorization is as valid as the original.

Print Name _____ Signature _____

Date _____ Social Insurance Number _____

INSTRUCTIONS

1. **ATTACH CERTIFICATE OF ATTENDING PHYSICIAN – DISMEMBERMENT OR LOSS (FORM NO. M4442).**
2. **ATTACH EMPLOYEE'S ORIGINAL ENROLLMENT CARD AND ANY CHANGES, IF YOU RETAIN THIS RECORD.**
3. **ATTACH ACCIDENT REPORT (IE. POLICE REPORT, EMPLOYER'S ACCIDENT REPORT).**

Please return the fully completed form and supporting documents to:

The Great-West Life Assurance Company
Group Life Benefits
PO 6000
Winnipeg MB R3C 3A5
Canada

Clear