

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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?* <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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. Personal information about you is kept in confidential files in the office 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. We collect, use and disclose the personal information to administer the plan, investigate and assess claims, and create and maintain records concerning claims.

Authorizations and Declarations

I authorize:

Great-West Life, any physician, surgeon or any other person who has examined me, any hospital in which I have received treatment, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with Great-West Life or working with my plan administrator, to exchange information, when relevant and necessary for the purpose of assessing my claim and to administering the plan;

I hereby declare that the answers given by me are, to the best of my 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 shall be 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
Box 6000
Winnipeg, Manitoba
R3C 3A5