Manulife

Group Benefits Life Claims

As a Plan Sponsor, complete page 1. You can print pages 2-10 and provide to the plan member or claimant for completion and submission to Manulife.

Please submit this form to the appropriate address:

For English Claims
Manulife
PO BOX 400 STN PLACE-D'ARMES
MONTREAL QC H2Y 3H1
Tel: 1-877-481-9169
Fax: 1-866-292-9050
Email: group_disability_claims@manulife.ca

For French Claims
Manulife
PO BOX 400 STN PLACE-D'ARMES
MONTREAL QC H2Y 3H1
Tel: 1-877-481-9169
Fax: 1-866-292-9050
Email: groupe_invalidite@manuvie.ca

If sending by courier
Manulife
ATTN: GROUP LIFE CLAIMS
2000 MANSFIELD, SUITE 220
MONTREAL QC H3A 2Y8

1 Nature of request

Please select the benefit type for which the claimant is applying.

◯ Death of the member ◯ Death of a dependent ◯ Death of a retiree ◯ Dismemberment

2 Plan sponsor's statement

This section should be completed by the plan sponsor. Declaration must be fully completed.

Plan contract number ________ Division ________ Class ________ Union local, if unionized ________

Plan sponsor name ________ Plan sponsor contact name (first, middle initial, last) ________

Plan sponsor address (number, street, suite) ________ Phone number ________

City ________ Province ________ Postal code ________

Email address ________

Plan member's name (first, middle initial, last) ________ Plan member's address (number, street, apt) ________

City ________ Province ________ Postal code ________

Date of birth (dd/mmm/yyyy) ________ SIN of plan member ________ Permanent employee ◯ Yes ◯ No

Plan member's employment start date (dd/mmm/yyyy) ________ Number of hours normally worked per week: ________ Plan member's last day worked (dd/mmm/yyyy) ________

Certificate number ________ Effective date of coverage (dd/mmm/yyyy) ________ Termination date of coverage, if applicable (dd/mmm/yyyy) ________

Was the plan member absent from work at the time of loss/death? ◯ Yes ◯ No Plan member occupation ________

If *yes*, what is the reason for absence from work: ◯ Sick leave ◯ Layoff ◯ Retired ◯ Leave of absence ◯ Other (please specify): ________

Plan member's salary at the last date worked $________ ◯ Annually ◯ Semi-monthly ◯ Bi-weekly ◯ Monthly ◯ Hourly ◯ Weekly

Effective date of salary (dd/mmm/yyyy) ________

Name of deceased/injured (first, middle initial, last) ________ Date of loss (dd/mmm/yyyy) ________

Beneficiaries

For plan sponsored administered group, provide a copy of the Plan Member Enrolment form/Beneficiary Designation form.

Beneficiary ________ Relationship ________ Date of birth (dd/mmm/yyyy) ________

Beneficiary ________ Relationship ________ Date of birth (dd/mmm/yyyy) ________

Please check claimed benefit(s) and specify amounts. For Plan Sponsor administered, submit copy of the Enrolment form for the plan member.

◯ Basic Life $________ ◯ Basic Accidental Death & Dismemberment $________ ◯ Paid Up Life $________

◯ Optional/Supplemental Life $________ ◯ Optional/Supplemental Accidental Death & Dismemberment $________ ◯ Dependent Life $________

◯ Other (please specify) ________ $________

Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Full name ________ Signature ________

Title ________ Date signed (dd/mmm/yyyy) ________