CHUBB

CRITICAL ILLNESS
EMPLOYER / ADMINISTRATOR STATEMENT
TO BE COMPLETED BY ADMINITRATOR OF
GROUP INSURANCE PLAN

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

SECTION I: PRIMARY INSURED/EMPLOYEE/MEMBER **(This section must be completed for all types of claims, including dependent claims)**			
Name of Primary Insured/Employee/Member:			**Employee ID:**
Name of Group Policyholder:			
Group Policy #		**Certificate #:**	
Name of Employer:		**Occupation:**	
Effective Date of Insurance:			
Date Employed/Membership Effective Date:			
Amount of Insurance Coverage: Mandatory Critical Illness: $		**Optional Critical Illness: $**	
Actively Working? ☐ Yes ☐ No		**If no, please provide date last worked:**	
Has there ever been a previous claim submitted for this employee to Chubb or any other insurer? ☐ Yes ☐ No			
If yes, please provide details and dates:			
Date of Sickness or Death:			
Considered an employee/member as defined in the policy at time of death and/or loss? ☐ Yes ☐ No			
Reason for leaving work: ☐ Disability ☐ Lay-off ☐ Dismissed ☐ Quit ☐ Leave ☐ Retired ☐ N/A – Actively at Work			
Did Sickness or Death arise out of, or in, the course of employment? ☐ Yes ☐ No			
If Yes, please attach incident report and provide details:			

SECTION II: DEPENDENT INFORMATION **(This section must be completed for a dependent spouse or child)**			
Name of Dependent:			**☐ Spouse ☐ Child ☐ Other:**
Effective Date of Insurance Coverage:			
Amount of Insurance Coverage: Mandatory Critical Illness: $		**Optional Critical Illness: $**	
Has there been any previous claim submitted for this dependent to Chubb or any other insurer? ☐ Yes ☐ No			
If Yes, please provide details:			

SECTION III: ADMINISTRATOR/EMPLOYER INFORMATION			
Administrator's Name (please print):			
Company Name:			
Mailing Address:		**City:**	
Province:	**Postal Code:**	**Phone #: ( )**	**Fax #: ( )**
Email Address (MANDATORY):			

Signature of Administrator _____ Date _____