



**ACCIDENTAL DEATH & DISMEMBERMENT
EMPLOYER / ADMINISTRATOR STATEMENT
TO BE COMPLETED BY ADMINISTRATOR 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 #	Division #:	Certificate #:
Name of Employer:	Annual Salary: \$	Occupation:
Effective Date of Insurance:		Date Employed:
Actively Working? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes", please provide details and dates:		
Date of Accident, Sickness or Death:		
Considered an employee/member as defined in the policy at time of death and/or loss? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Reason for leaving work <input type="checkbox"/> Disability <input type="checkbox"/> Lay-Off <input type="checkbox"/> Dismissed <input type="checkbox"/> Quit <input type="checkbox"/> Leave <input type="checkbox"/> Retired <input type="checkbox"/> N/A – Actively at Work		
Did Accident, Sickness or Death arise out of, or in, the course of employment? <input type="checkbox"/> Yes <input type="checkbox"/> 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:		<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:
Effective Date of Insurance Coverage:	Amount of Insurance Coverage:	
Has there been any previous claim submitted for this dependent to Chubb or any other insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please provide details:		
SECTION III: BENEFICIARY INFORMATION (Please complete for all death claims and attach beneficiary designation and change forms)		
Beneficiary name (if applicable):	Relationship:	
Address:	Phone #: ()	
SECTION IV: ADMINISTRATOR/EMPLOYER INFORMATION		
Administrator's Name (please print):		
Company Name:		
Mailing Address:		
Province:	City:	Postal Code:
Phone #: ()	Fax #: ()	Email Address:

Signature of Administrator _____ Date _____

NOTE: PLEASE ATTACH A COPY OF THE INCIDENT REPORT TO THIS STATEMENT.