



- Death
- Critical illness
- Accidental dismemberment or loss of sight

We cannot settle this claim unless all questions are answered adequately.

A. Identification of employee

Last name	First name	Date of birth YYYY-MM-DD
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B. Identification of individual concerned (if other than the employee)

Last name	First name	Date of birth YYYY-MM-DD
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C. Identification of employer

Name of employer		
Address - No., Street		
City	Province	Postal code
Telephone no. Area code + number	Extension	
Contract/Group no.	Account/Division no.	Identification/Certificate no.

D. Employer's statement

1. Date of hiring YYYY-MM-DD	2. Coverage effective date YYYY-MM-DD
3. Does the employee work on a part-time basis (more than 25% and less than 75% of time)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, specify the % compare to full time work _____ %
4. Does the employee work on a full-time basis (more than 75% of time)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Was the insured disabled before the event? <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Date of beginning of disability YYYY-MM-DD
7. Last date worked YYYY-MM-DD	8. Salary at beginning of disability
	9. Annual salary at the date of the event
10. If this is a <u>death</u> claim, would you like the payment to be sent to the employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Remarks	

E. Declaration

I declare that the information provided above is complete and true.

Signature of employer's representative **Title** **Date**