Life Insurance Benefit Claim Form

Section 1 Instructions

1. Please review all instructions before completing both sides of this claim form.
2. Photocopies, original documents or faxed documents are acceptable.
3. We reserve the right to request additional documents after reviewing the information received.
4. If you wish to request advance payment of Life Insurance benefits, please contact ENCON to obtain the appropriate form.

Death of the Plan Member

Sections to complete:
Section 2 – Claimant's Statement
Section 3 – Information About the Deceased
Section 4 – Employer's Statement

Documents to provide:
- Original Death Certificate

Death of the Spouse

Sections to complete:
Section 2 – Claimant's Statement
Section 3 – Information About the Deceased

Documents to provide:
- Original Death Certificate

Death of a Dependent Child

Sections to complete:
Section 2 – Claimant's Statement
Section 3 – Information About the Deceased

Documents to provide:
- Original Death Certificate
- Copy of the deceased's Birth Certificate
- Confirmation of full-time attendance at a recognized educational institution if the child is over age 21 but under age 26.
- Medical Assessment confirming an incurable and chronic disability if the child is over age 21 and was disabled before age 21.

Section 2 Claimant's Statement

Please print clearly

Plan Member Information

Name of Employee

Identification No. | Social Insurance No.

Address

Claimant Information

Name of Claimant

Address

Telephone

In what capacity do you make this claim?

❑ Beneficiary ❑ Plan Member ❑ Executor ❑ Spouse ❑ Other (specify):

I hereby certify that the answers given in this form are complete and true to the best of my knowledge. I authorize any physician, health professional, hospital, institution or other organization to disclose to the insurer any information pertaining to the deceased person.

Signature of Claimant | Date (yyyy/mm/dd)

Section 3 Information About the Deceased

General Information About the Deceased

❑ Plan Member ❑ Spouse ❑ Dependent Child

Name of Deceased

Gender

❑ Male ❑ Female

Date of Birth (yyyy/mm/dd)

Smoker Status

❑ Never smoked ❑ Smoker or Ex-smoker, as of what date:

Marital Status at time of death ❑ Single ❑ Common-Law ❑ Married ❑ Civil Union (Quebec only) ❑ Separated ❑ Divorced ❑ Widowed

If common-law:

Name of Spouse

Start Date of Relationship (yyyy/mm/dd)

Has a child been born as a result of this union?

❑ Yes ❑ No

Information About the Death

Date of Death (yyyy/mm/dd)

Cause of Death

❑ Natural ❑ Accidental ❑ Homicide ❑ Suicide

Briefly describe the nature of the illness or the circumstances that caused the death:

Section 4 Employer's Statement

Plan Member Information

Name of Employee

Employment Start Date (yyyy/mm/dd)

Employment Status

❑ Full-time ❑ Part-time ❑ Other (specify):

Last Day the Plan Member was Actively at Work (yyyy/mm/dd)

If the Plan Member was not Actively at Work up to the date of death, specify the reason:

❑ Sick leave ❑ Vacation ❑ Voluntary departure ❑ Layoff ❑ Other (specify):

Regular Annual Gross Salary on the Last Day the Plan Member was Actively at Work

If Different, Regular Annual Gross Salary on the Date the Death Occurred

Plan Administrator Information

Name of Plan Administrator

Job Title

Name of Employer

Telephone

Signature of Employer

Date (yyyy/mm/dd)