THE Great-West Life ASSURANCE COMPANY

Group Life / Accidental Death & Disablement / Dependents Death Claim Report (to be used for all plans)

Check all claim(s) that are being reported: ☐ Group Life Claim ☐ Accidental Death & Disablement Claim ☐ Dependent Insurance Claim

CIVIL SERVICE SUPERANNUATION LIFE PLAN Group Policy Number: **330780 / 330785**

Division Number: _____ Certificate/SIN Number of Employee/Retired Member: _____

Part 1: Policyholder/Employer Statement

☐ **Group Life Insurance: Deceased Employee/Retired Member (check here if claim is for deceased employee/retired member)**

Full Name of Deceased: _____
Last Name First Name Initial

Full Address of Deceased: _____

Deceased's Date of Birth: _____ Date of Death: _____ Occupation: _____

Insurance Plan Entry Date: _____ Last Date Worked: _____

Reason for Leaving Work: _____

Insurance Salary at Last Date Worked: $_____ hrly x _____ hrs; or $ _____ bi-weekly: or $ _____ yearly

Insurance Class: _____ Amount of Group Life Insurance Claimed: $ _____

☐ **Accidental Death & Disablement (check here if also claiming for Accidental Death - n/a for retired members)**

Amount of Accidental Death Insurance claimed: $_____ Date of Accident: _____

Circumstances of Accident: _____

☐ **Dependents Insurance: Deceased Dependent (check here if claim is for deceased dependent)**

Full Name of Deceased Dependent: _____
Last Name First Name Initial

Deceased Dependents Date of Birth: _____ Date of Death: _____ Relationship to Employee/Retired Member: _____

Full Name of Employee/Retired Member: _____
Last Name First Name Initial

Full Address of Employee/Retired Member: _____

Number of Dependent Units: _____ Amount of Dependents Insurance Claimed: $ _____

Declaration

I hereby declare that the above information is accurate and correct.

Employer/Department Name: _____ Date: _____

Signature: _____ Title: _____

Return above to: Civil Service Superannuation Board, 1200-444 St. Mary Avenue, Winnipeg, MB R3C 3T1

M62(330780)-8/06

Part 2: Claimant's Statement

Group Policy Number: **330780 / 330785** Division Number _____ Employee/Retired Member Certificate/SIN Number: _____

Deceased's Full Name: _____ Cause of Death: _____
Last Name First Name Initial

Claimant's Full Name: _____ Claimant's SIN/Social Security Number: _____
Last Name First Name Initial

Claimant's Date of Birth: _____ Claimant's Phone Number: (____) _____

Claimant's Full Address: _____

Claimant's Basis of Claim: ☐ Named Beneficiary/POA **or** ☐ Minor Trustee **or** ☐ Estate Executor/Administrator

Please attach an original Certificate of Death or a notarized copy of Certificate of Death or an original Funeral Director's Certificate or a notarized copy of Funeral Director's Certificate. Return all forms to either your employer or the Civil Service Superannuation Board, 1200-444 St Mary Ave, Winnipeg, MB R3C 3T1.

Protecting your Personal Information

At The Great-West Life Assurance Company, we recognize and respect the importance to privacy. Personal information about you is kept in confidential files at the office of Great-West or the offices of an organization authorized by Great-West. We limit access to personal information in your files to Great-West staff or persons authorized by Great-West who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the personal information to assess your claim and to administer the group benefits plan.

Authorizations and Declarations

I authorize Great-West, any healthcare provider, the deceased's plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West or working with the deceased's plan administrator to exchange personal information, when necessary to assess my claim and to administer the plan.

I have provided the information on this form in order to obtain payment of Group Life proceeds payable to me (in a personal capacity or on behalf of a beneficiary) and I hereby declare that I am legally entitled to receive all or a share of the proceeds payable under the Group Life Policy. I certify that by making payment to me, Great-West has met its obligation to me. I further declare that the answers given by me are, to the best of my knowledge and belief, true and full, and I have withheld no material facts from Great-West.

I hereby declare that the above information is accurate and complete.

Claimant Signature _____ Date _____

Witness Signature _____ Date _____