Manulife

Death claim

Combined statements

Disability claims department

P.O. Box 4002 STN B
Montréal, Québec H3B 4M2
Fax: 1 866 645-4180

PLAN SPONSOR STATEMENT

Plan sponsor name | Plan contract no. | Division no. | Plan member certificate no.

Plan sponsor address (no., street) | City | Province | Postal code

Member surname | Given name(s) | Initial | Class no. | SIN

Main residence address (no., street, apt.) | City | Province | Postal code | Date of birth (D D M M M Y Y Y Y)

1. Occupation | 2. Effective date of the Plan member certificate (D D M M M Y Y Y Y) | Termination date of the Plan member certificate (D D M M M Y Y Y Y)

3. Life volume coverage | Basic | Optional | Dependent | Other

4. Absence during the last twelve months worked ☐ Yes ☐ No From (D D M M M Y Y Y Y) to (D D M M M Y Y Y Y)

5. Nature of request
☐ Death of the Member
☐ Death of a dependent
☐ Death of a retiree

6. Deceased surname and given name(s)

If death of Member, please answer questions 7-10

7. First day worked ☐ Full time ☐ Part time Date (D D M M M Y Y Y Y)

8. Last day worked ☐ Full time ☐ Part time Date (D D M M M Y Y Y Y)

9. Reason for absence ☐ Sick Leave ☐ Retired ☐ Vacation ☐ Lay Off ☐ Other

10. Basic salary on the last day of work ☐ Weekly ☐ Monthly ☐ Annually $

If death of a dependent, please answer question 11

Number of hours worked per week:

11. Was the participant actively at work on the date of the dependent's death? ☐ Yes ☐ No

If no, indicate why:

We hereby certify that the information given above is accurate.

Employer's email address

Nom (en lettres moulées) | Téléphone n° | Authorized employer signee | Date (D D M M M Y Y Y Y)

CLAIMANT STATEMENT (EACH CLAIMANT MUST COMPLETE AND SIGN A CLAIMANT STATEMENT UNLESS HE/SHE IS A MINOR)

Deceased surname | Given name(s) | Date of birth (D D M M M Y Y Y Y)

Date of death (D D M M M Y Y Y Y) | Cause of death | If caused by an accident, specify the circumstances

Claimant (surname and given names) | SIN | Date of birth (D D M M M Y Y Y Y)

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Other | Claimant's email address

I claim in the capacity of ☐ Beneficiary ☐ Executor ☐ Legatee ☐ Heir ☐ Other

I authorize all physicians and other persons who have treated the deceased and all hospitals, institutions and government authorities to provide to Manulife all information in their possession or within their knowledge with respect to the deceased and to honour a photocopy of this authorization.

Address (no, street, apt.) | City | Province | Funeral Home Name

Postal code | Telephone no. | Address | Postal code

Claimant signature | Telephone no. | Email address

Date (D D M M M Y Y Y Y)

In providing this or other claims forms for the convenience of the Claimant, Manulife does not admit any liability or waive any of its rights. Please note that Manulife reserves the right to request official documents and originals in order to proceed with the claim.

ATTENDING PHYSICIAN'S STATEMENT

Please note that this section needs to be completed for claims for which the life insurance amount is more than $300,000.

However, Manulife reserves the right to request that the 'Attending Physician's Statement' be completed although the claim amount is less than $300,000.

This medical Plan member certificate is in conformity with the July 24, 1948, recommendations of the World Health Organization in Geneva. It was adopted by all states in the United States and all provinces in Canada.

In order to ensure that vital statistics are accurate, please refer to the International Listing of Causes of Death.

Deceased surname	Given name(s)	Age at death	or	Date of birth D D M M M Y Y Y Y

Address at time of death (no., street)

Place of death (if deceased in a hospital or institution, please give name)	Date of death D D M M M Y Y Y Y

Cause of death (state only one cause under each paragraph a, b and c)*	Interval between onset of illness and death
a) Pre-existent causes. Morbid conditions having eventually caused the above condition. Initial morbid condition to be mentioned last.	a)
b) Caused by or resulting from	b)
c) Caused by or resulting from	c)

*Illness or morbidity directly related to cause of death. This does not relate to the mode of death, for example, heart failure, etc., but to the illness, lesion or complication which caused death.

Other important morbid conditions related to the death, but not related to the illness or the morbid condition, which caused the person to die.

Date on which first treatment was administered for last condition causing death D D M M M Y Y Y Y

Date on which last treatment was administered for last condition causing death D D M M M Y Y Y Y

Specify whether death was due to an accident, suicide or homicide and give a short description of the circumstances.

Was there an inquest? ☐ Yes ☐ No Was there an autopsy? ☐ Yes ☐ No

If "Yes", who conducted the inquest or performed the autopsy and what were the findings?

To your knowledge, has the deceased smoked cigarettes, small cigars (cigarillos), a pipe or used smoking cessation aids products during the past 12 months? ☐ Yes ☐ No

Have you treated the deceased or has he or she consulted you over the three years prior to the last illness? ☐ Yes ☐ No

To your knowledge, over the last three years, has the deceased been treated by other physicians or in a hospital or other institution? ☐ Yes ☐ No

If you have answered "Yes" to one of these questions, please provide the following information:

Name	Address	Nature of illness or lesion	Date
			D D M M M Y Y Y Y
			D D M M M Y Y Y Y
			D D M M M Y Y Y Y
			D D M M M Y Y Y Y

Physician signature	Date D D M M M Y Y Y Y

Address	City	Province	Postal code

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