

Life Claim

Please see instructions on page 2 for completing this form.

Instructions for completion & requirements ○ PLAN MEMBER LIFE CLAIM (please print all answers)

Complete page 3 & 4 of this form

- Plan administrator complete and sign section 1,
- Claimant complete and sign section 2.

Please check for the following requirements:

Proceeds UNDER \$300,000

Original or notarized copy of Funeral Director's Statement of Death, and newspaper death report or obituary notice (if available)

Attending Physician's Statement (page 7 of this form)

Proceeds \$300,000 and OVER

- Original or notarized copy of Provincial Death Certificate
- Attending Physician's Statement (page 7 of this form)

Accidental Death

 Attending Physician's or Coroner's Statement (page 9 of this form)

Plan sponsor administered group (please complete section for plan sponsor administered groups)

ORIGINAL of the Plan Member Enrolment form

DEPENDANT LIFE CLAIM (please print all answers)

Complete page 5 & 6 of this form

- Plan administrator complete and sign section 1,
- Plan member complete and sign section 2.

Please check for the following requirements:

Proceeds UNDER \$300,000

Original or notarized copy of Funeral Director's Statement of Death, and newspaper death report or obituary notice (if available)

Original or notarized copy of Provincial Death Certificate

Proceeds \$300,000 and OVER

- Original or notarized copy of Provincial Death Certificate
- Attending Physician's Statement (page 7 of this form)

Accidental Death (if applicable)

 Attending Physician's or Coroner's Statement (page 9 of this form)

Plan sponsor administered group (please complete section for plan sponsor administered groups)

OCOPY of the Plan Member Enrolment form

Miscellaneous requirements

Payments to minor beneficiary

ORIGINAL or NOTARIZED copy of Court appointment of Guardianship of the Estate of the Minor

Payments to estate

ORIGINAL or NOTARIZED copy of the Probated Will or Letters of Administration for proceeds \$50,000 and over.

Manulife Financial

HALIFAX NS B3J 2X5

Beneficiary has died before the plan member

ORIGINAL or NOTARIZED/CERTIFIED copy of deceased Beneficiary's Proof of Death

Manulife Financial Waterloo Group Life Claims Office PO BOX 800 STN C KITCHENER ON N2G 4Y5

Tel: 1-877-481-9169

Tel: 1-866-447-4517 (519) 747-7000 (902) 453-4300 Fax: (519) 579-3680 Fax: (902) 429-7292

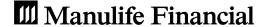
If you live in Quebec:

Manulife Financial Montreal Group Life Claims Office PO BOX 395 STN PLACE-D'ARMES MONTREAL QC H2Y 3H1

Tel: 1-866-236-6313 (514) 288-6268 Fax: (514) 286-6738

Halifax Group Life Claims Office

PO BOX 1030 STN CENTRAL



Group Benefits Plan Member Claim

Life and Accidental Death (if applicable)

For dependant death claim use pages 5 & 6. Please print clearly.

1 Plan administrator's statement for death of plan member

Plan contract number(s)	Class	Division	number	Union loca	I Pla	an member certificate number
Plan sponsor's name			Deceased	plan member	's job titl	le
Deceased plan member's name (last	, first, middle initia	l)			Date of	birth (dd/mmm/yyyy)
Date of employment (dd/mmm/yyyy)	Beneficiary's na	ıme (last,	first, middle initial))	Relation	nship
Check applicable benefit(s) and spec	cify face amounts.					
O Basic Life \$	O Paid Up Life \$	S		Basic	Accider	ntal Death \$
Optional Life \$	O Permanent Pa	aid Up Life	e \$	Optio	nal Acci	dental Death \$
Date last worked (dd/mmm/yyyy)	Salary as of la	ast day w	orked	Annually Monthly	\simeq	mi-monthly Weekly weekly Hourly
Regular number of hrs. Salary effe worked/week	ctive date (dd/mm	m/yyyy)	Date of death (do	d/mmm/yyyy)		te of termination applicable) (dd/mmm/yyyy)
Did the plan member contribu	ite part of the i	premiur	n payment?	Yes	○ No	
If death occurred after date la	·			status:		
Retired Temporary la	ayoff O	ismissed tesigned				
			w alaim for dia	ability ban	ofito fi	lad during this pariod?
If plan member was disabled Yes No If "Yes".	phor to death, please provide		-	•		ied during this period?
Claim number	Name of carr					
Was this death accidental? If "Yes", please have the Atte Statement (page 9) complete	nding Physicia		Joroner's	e of accident	(dd/mm	m/yyyy)
Did the accident occur while						
	please give lo		~	accident.		
Location of accident	Address of a					
For Optional Life only - Was p	olan member i	neurad	at non-smoker	rates?		
	attach copy of			rateo.		
	.,	_				
Plan member insurance class (if applicable) Most recent effect member's coverace member's coverace member's coverace member's coverace member's coverace member's coverace member membe			al effective date of er's coverage (dd/	f plan mmm/yyyy)		to which premiums were paid mm/yyyy)
I certify that the information ir	this form is tr	ue and	complete to the	he best of	mv kn	owledge.
Authorized signature	101111110 (1		Date signed (dd/m			code and phone number
x			- ,		()
Mailing address (number, street)		City		Provi	ince	Postal code
The information in this statemen						

administered groups only.

Please submit ORIGINAL

enrolment form for this plan

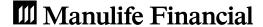
member.

For plan sponsor

Declaration

the information you consent to such unedited release of any information contained herein.

2	Claimant's statement for death of a plan member	Claimant's name (last, first, middle initial)					Plan numbers of other Manulife Financial plans for which a claim is being made		
		Claimant's mailing address (number, street)			City		Province Postal code		
		Relationship to deceased plan member	er	Claimant's	s date of b	irth (dd/mmm/yyyy)	Claimant's Soci	al Insurance Number	
		Cause of death							
	IF DEATH WAS ACCIDENTAL, please answer the following	Date of accident (dd/mmm/yyyy)		f accident M. O P.	M.				
	questions. Use a separate sheet of paper if required. If not accidental, please read and sign below.	Fully describe the accident; where	was the	deceased	and what	t was he/she doing	at the time of the	e accident?	
	Please provide the names and addresses of any witnesses to the accident.	Name(s)				Address(es)			
		Did the deceased ever suffer f				ny bodily or men	ntal disorder?		
	Claimant's certification and authorization for all death claims	I certify that the information in this any further verbal or written state. I hereby claim the group life insur	ment pr	ovided by	me will l	be true and comple	ete to the best of	of my ability.	
		(name of deceased)							
		I understand that Manulife Financial will investigate this claim and may require information related to the deceased health, employment, police investigations, autopsy or coroners inquest reports. I authorize any person or organization who has information pertaining to this claim, including any employer, group plan administrator, health care professional, health care institution and any other medically-related facility, insurer police, coroner and investigative agency, to release and exchange information requested by Manulife Financial artists claims service providers for the purpose of administering the group plan and investigating and assessing this claim. I authorize Manulife Financial, its reinsurers and its claims service providers to collect, to use and to exchange with the persons or organizations listed above and/or each other any information needed for the purpose of administer the group plan and investigating and assessing this claim. I authorize the use of my Social Insurance Number for the purpose of tax reporting. I agree that a photocopy or electronic version of this authorization shall be as valid as the original. I understand that information relating to Manulife Financial's privacy policies is available upon written request, on Manulife Financial's website, www.manulife.ca or through the Plan Sponsor.						any employer, group elated facility, insurer, Manulife Financial and/or and assessing this e and to exchange with ourpose of administering ginal.	
		I understand that any personal inta authorization, will be kept in a gro limited to: • Manulife Financial employees, • Persons to whom I have grante • Persons authorized by law. I have the right to request access inaccurate information corrected.	oup life, represe ed acces s to the p	health, or intatives, ss; and	disability	y benefits file. Access, and service prov	ess to my perso	onal information will be rformance of their jobs;	
	Claimant's signature	Claimant's signature					Date siç	gned (dd/mmm/yyyy)	
							,		



Group Benefits Dependant Claim

Life and Accidental Death (if applicable)

For plan member death claim use pages 3 & 4. Please print clearly.

1	Plan administrator's
	statement for death of
	dependant -
	plan member details

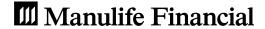
Plan contract number(s)	Class	Division	number	Unior	n local	Plan	member certificate numb
Plan sponsor's name			Employer's n	ame (if di	ferent fro	om plan	sponsor)
Plan member's name (last, first, mide	dle initial)		Date of birth (dd/mmm/yyyy				
Plan member's mailing address (nun	nber, street)	City			Province	:	Postal code
Date of employment (dd/mmm/yyyy)	Job title						
Check applicable benefit(s) and spec	cify face amounts	3.					
Basic Life \$	_	cidental De	ath \$		_ 0	Paid U	p Life \$
Optional Life \$	_		Death \$		_		•
Date last worked (dd/mmm/yyyy)	Salary as of			Annua	ally () Sami	-monthly () Weekly
	\$)	Month	. ~) Bi-we	
Regular number of hrs. Salary effe worked/week	ective date (dd/mr	mm/yyyy)	Date of death	(dd/mmm	′уууу)		of termination blicable) (dd/mmm/yyyy)
f death occurred after date la	ast actively at	work, ple	ease indicate	e status	:		
Retired Temporary I	layoff	Dismissed Resigned	Jaco maioat	o otatao	•		
f plan member was disabled							
Claim number Deceased dependant's name (last, f	Name of ca			Rela	ationship	to plan	member
Was this death accidental?	○ Yes ○	No					
f "Yes", please have the Atte Statement (page 9) complete	ending Physic	ian's or C	coroner's	ate of acc	cident (do	l/mmm/	уууу)
Did the accident occur while	dependant wa	as workin	g?	af a a a i d	la må		
	please give lo		na address	or accid	ent.		
Location of accident	Address of	accident					
	•		lependant s	pouse ir	nsured	at nor	n-smoker rates?
	attach copy of	of declara	ition.				
Yes No If "Yes", Plan member insurance class Most recent effect member's coverage.	tive date of plan	Origina					which premiums were pan/yyyy)
Yes No If "Yes", Plan member insurance class (if applicable) Most recent effect member's coverage member's coverage.	tive date of plan ge (dd/mmm/yyyy	Origina covera	al effective date ge (dd/mmm/y	ууу) .	((dd/mmr	n/yyyý)
Yes No If "Yes", Plan member insurance class (if applicable) Most recent effect member's coverage of the cov	tive date of plan ge (dd/mmm/yyyy	Origina covera	al effective date ge (dd/mmm/y	o the be	st of my	dd/mmr y knov	n/yyyý)
Yes No If "Yes", Plan member insurance class (if applicable) Most recent effect member's coverage member's coverage member and the information in Authorized signature	tive date of plan ge (dd/mmm/yyyy	Origina covera	al effective date ge (dd/mmm/y	o the be	st of my	dd/mmr y knov area coo	n/yyyy) vledge.
Plan member Most recent effec	tive date of plan ge (dd/mmm/yyyy	Origina covera	al effective date ge (dd/mmm/y	o the be	st of my	dd/mmr y knov area coo	vledge. de and phone number

For plan sponsor administered groups only. Please submit COPY

enrolment form for this plan member.

Declaration

Plan member's statement for death of a dependant	Deceased dependant's address (number,	street)	City		Province	Postal code
	Deceased's date of birth (dd/mmm/yyyy)	Deceased's	s marital status	If deceased w		child and attending school,
	Cause of death				Date of deat	h (dd/mmm/yyyy)
	If deceased died in hospital, pleas	se give da	te admitted	>	(dd/mmm/yy	yy)
	At time of death, was the depend	·	yed? er of hours wo		hours per week	
	Was he/she dependent on you fo	r support?	Yes) No		
	Was the dependent confined to a			became effe	ective?	
	○ Yes ○ No If "Yes," indicate date discharged	(dd/mmm	ууууу)			
Please provide the following information regarding YOURSELF.	Your name (last, first, middle initial)					
3	Your Social Insurance Number	Relation	nship to deceased			
Plan member's certification and authorization for all death claims	I certify that the information in this for that any further verbal or written state. I hereby claim the group life insurance.	ement provi	ded by me will be	e true and cor	nplete to the b	est of my ability.
	(name of deceased)			_		
	I understand that Manulife Financial health, employment, police investigat I authorize any person or organization plan administrator, health care profest police, coroner and investigative age and/or its claims service providers for this claim. I authorize Manulife Financial, its rein the persons or organizations listed all the group plan and investigating and I authorize the use of my Social Insurance I agree that a photocopy or electronic I understand that information relating Manulife Financial's website, www.m	n who has it is	sy or coroners in nformation perta alth care institution ase and exchange of administering its claims service each other any this claim. Deer for the purpose it is authorization authorization of through the Plant in thr	nquest reports ining to this clan and any other information and the group providers to information new se of tax reports shall be as vacy policies is an Sponsor.	laim, including ler medically-re requested by plan and invest collect, to use eeded for the pring.	any employer, group elated facility, insurer, Manulife Financial igating and assessing and to exchange with surpose of administering ginal.
	I understand that any personal inform authorization, will be kept in a group limited to: • Manulife Financial employees, represents to whom I have granted at Persons authorized by law. I have the right to request access to inaccurate information corrected.	life, health, resentatives ocess; and	or disability bene s, reinsurers, and	efits file. Acce	ss to my perso	nal information will be formance of their jobs;
Plan member's signature	Plan member's signature				Date sign	ed (dd/mmm/yyyy)
					'	



Group Benefits Attending Physician's Report

If there is a charge for the completion of this form, payment is the responsibility of the claimant. Please print clearly.

Completed reports should be returned to:	Plan contract number(s)	Divisi	Division number Union local Plan m								
	Plan administrator's name (last,	first, middle initial)									
	Plan administrator's mailing add	ress (number, street)	City	Province	Pos						
	The Medical Certification fol 1948. It has been accepted conform to the International administrator at the address	in Canada and the U List of Causes of De	Inited States.	In the interest of	f accurate	vital statis	stics, plea				
Physician's report	Deceased's name (last, first, mid	ddle initial)	Place of o	death		Date of dea	ath (dd/mn	nm/yyyy)			
	If death occurred in an institution or hospital, please give name						Age a	at death			
	Residence address at death (nu	ımber, street)	City		Pos	Postal code					
Cause of death Enter only one cause for	Disease and condition of mean the mode of dying	such as heart failure	, asthenia, etc	c. It							
each of a, b and c.	means the disease, injury or (a)	, , , , , , , , , , , , , , , , , , , ,					Interval between onset and death				
	Antecedent causes. (Morbid conditions, if any, giving rise to the above cause (a) stating underlying causes last).						Interval between onset and death				
	Due to (b)				(b)						
	Due to (c)				(c)						
	To your knowledge, did the		smoke? how many y		of years						
	Date of first attendance in last illness	(dd/mmm/yyyy)		Date of last at in last illness	tendance	e (dd/mmi	m/yyyy)				
	If death was due to accide	ent, suicide or hon	nicide, speci	fy which and d	escribe I	briefly.					
	Was an inquest held? (If "Yes," to either of the al	Yes No		autopsy perfor	med?	Yes	○ No				
	ii Tes, to etitlel of the al	bove, by whom an	u what illiuli	ıys :							
	Have you treated or advis last illness?		_				Yes	○ No			
	Did the deceased, to your five years from any other				st		Yes	○ No			
If "Yes," to either of the above, please provide the	Name	Address		Nature of illnes	ss/injury		proximat				
following information.							/mmm/yyy				
						(ad/	mmm/yyy	y)			

Attending physician's personal information

Attending physician's full name		Degree or qu	alification
Address (number, street)	City	Province	Postal code
Area code and phone number ()			
Attending physician's signature X		Date signed (dd/mmm/yyyy)

Attending physician's signature

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife Financial and might be accessible by third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.



Group Benefits

Attending Physician's or Coroner's Statement for Accidental Death

If there is a charge for the completion of this form, payment is the responsibility of the claimant. Please print clearly.

Completed reports should be returned to:	Plan contract number(s)	Divisi	on numbe	er	Union	local	Plan me	ember certificate number
	Plan administrator's name (last, first, mid	ddle initial)						
	Plan administrator's mailing address (nur	mber, street)	City			Province	•	Postal code
Attending physician's or coroner's statement for	Deceased's name (last, first, middle initia	al)		Date of injury (de	d/mmm	/yyyy)	Date o	of death (dd/mmm/yyyy)
accidental death	What was the precise nature and	d extent of t	he inju	ry?				
	What was the primary or immedi	iate cause o	of death	1?				
	Was the deceased ever treated	for a simila	r condi	tion?				
	Yes No If "Yes," wh	ere and by	whom?					
	Were there any contributing or re			eath?				
	Was the injury, described above Yes No If "No," plea			pendent of all	other	causes	s, suffic	cient to cause death?
	At the time of the injury, was the	deceased	under tl	he influence o	of alco	hol or n	arcotic	c drugs?
			olood al	cohol content	and t	ype of c	drug.	
	Blood alcohol content T	ype of drug						
	Was an autopsy performed?	Yes O	No					

Please complete page 10 of this form.

Attending physician's or coroner's personal information

Attending physician's or coroner's full name	Degree or qu	Degree or qualification				
Address (number, street)	City	Province	Postal code			
Area code and phone number ()						
Attending physician's or coroner's signature X		Date signed ((dd/mmm/yyyy)			

Attending physician's or coroner's signature

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife Financial and might be accessible by third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.