Application for Accidental Dismemberment or Specific Loss - Policyholder Statement

Group Policy No.: **161938** Division No.: ______________________

Name of Employee: ____ Employee No.: ______________________

Address: ____

Date of Birth: __________________________ Date of Employment: ____

Amount of Accidental Dismemberment or Loss Benefit: $ ______________________ Date last reported for work prior to accident: __________________________

Has the employee returned to work? ☐ Yes ☐ No

If reason for leaving was other than the accident please give details. ____

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Authorized Plannera Signature		Authorized Plannera Signature	
Date (mm/dd/yy)	Telephone No.	Date (mm/dd/yy)	Telephone No.

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canada life™

Application for Accidental Dismemberment or Specific Loss-Claimant's Statement Part 1

Plannera PENSIONS & BENEFITS

INSTRUCTIONS

1. **COMPLETE PART 1 AND AUTHORIZATION ON THE LAST PAGE OF PART 2. ASK YOUR PHYSICIAN TO COMPLETE PART 2.**
2. **FORWARD BOTH PART 1 AND PART 2 TOGETHER TO:**
   Plannera
   110 - 1801 Hamilton Street
   Regina, SK S4P 4W3

Group Policy No.: **161938** Div No.: ____________ Employee No.: ____________

Name: ____

Address: ____

Street   City   Province   Postal Code

Please check which Dismemberment or Specific Loss is being applied for:

- ☐ Both hands or both feet
- ☐ Entire sight of both eyes
- ☐ One hand and one foot
- ☐ One hand and entire sight of one eye
- ☐ One foot and entire sight of one eye
- ☐ Complete speech and complete hearing in both ears
- ☐ Use of both hands or both arms or both legs
- ☐ Use of one hand and one leg
- ☐ Use of one arm and one leg
- ☐ Paraplegia
- ☐ Hemiplegia
- ☐ Quadriplegia
- ☐ One arm or one leg or one hand or one foot
- ☐ Entire sight of one eye
- ☐ Use of one hand or one arm or one leg
- ☐ Complete loss of speech
- ☐ Complete loss of hearing in both ears
- ☐ Thumb and index finger of same hand

No more than $50,000 will be paid for all the losses incurred in any one accident.

Date of Accident: ____________ Did the accident take place in the course of employment?* ☐ Yes ☐ No

Briefly describe how the accident occurred: ____

____

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Name of hospital if you were confined: ____

Dates of hospitalization: ____

Name of Attending Physician: ____

Physician's Address: ____

Street   City   Province   Postal Code

Date of first treatment: ____

* If yes, please provide your accident report.

AUTHORIZATIONS AND DECLARATIONS

Protecting your Privacy

We take your privacy seriously. We keep all your personal information in a confidential file in our offices, or the offices of an organization we've authorized. The only person with access to the information are: people working at Canada Life and those we've authorized, who need the information to do their jobs and manage your claim, those whom you've given access, those authorized by law both within Canada and in any other jurisdiction where your personal information is held. For a copy of our Privacy Guideline see: canadalife.com or you can write to Canada Life's Chief Compliance Officer.

Authorizations and Declarations

I authorize Canada Life, any healthcare provider, the plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life or working with the deceased's plan administrator, within or outside Canada, to exchange personal information, when necessary to investigate and assess my claim, to administer the group benefits plan and to audit the assessment of the claim. I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

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, Canada Life has met its obligation to me. By signing below, I confirm that: I have read, understand and agree with the contents of this form and authorize Canada Life to collect, use, and disclose my personal information, all statements I have made about my claim are true and complete, my authorization is valid until I cancel it in writing, and a photocopy or electronic copy of this authorization is as valid as the original.

Signature ____________________ Date ____________________

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