Equitable™

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CLAIMANT'S STATEMENT – ENTITIES

Complete this form for claims if the Claimant is an entity. For policies where the claimant is an Individual, completed the 682TC for Term or Critical Illness policies, or 682WU form for Whole Life or Universal Life policies. These forms can be found on EquiNet.

INSTRUCTIONS

1. If the Policy is assigned:

   a) A Statement should be completed by the assignee as well as the beneficiary. Payment will be made jointly to the beneficiary and the assignee.

Number of each policy under which a claim is being made	Email Address
Deceased's Name (in full)	Province or State of Domicile
Date of Death	Cause of Death
Place of Death	Date and Place of Birth

Names and addresses of all Physicians who attended the deceased in the past five years.

Name	Address	Date	Reason

Names and locations of all Hospitals or Institutions where the deceased was treated in the past three years.

Hospital or Institution	City or Town	Date

To your knowledge, was the deceased a smoker? ☐ Yes ☐ No

If yes, please indicate the length of time (approx.) _____ Please check one: ☐ cigarettes ☐ pipes ☐ cigars

To your knowledge, did the deceased ever stop smoking? ☐ Yes ☐ No If yes, when and for how long? _____

Did the deceased have any other life insurance policies in force at the time of death? ☐ Yes ☐ No

CLAIMANT'S STATEMENT – ENTITIES

1. Entity Identification

Please complete the applicable section:
a) Corporation
b) Sole Proprietor/Partnerships/Associations/Unions
c) Not For Profit Organization
d) Estate or Trust

a) Corporation

Full Legal Corporate Name		Business Number or Quebec Enterprise Number	
Incorporation Number		Jurisdiction (federal/provincial)	
Address (street number and name)			City
Province	Postal Code	Email Address	
Describe principal business activity (if a holding company, describe the nature of businesses held)			
Do you carry on business under any other names? Please list:			

I have attached the following evidence of existence (choose at least one):

☐ a copy of articles of incorporation ☐ business license ☐ registration of business name or corporate search

Additionally, I have attached the following records of provisions relating to the power to bind the corporation (authority of officers to sign on behalf of the corporation). (Choose and attach at least one):

☐ a copy of our Bylaws ☐ our most recent Director's Resolutions regarding signing authorities ☐ Signing Authorities Certificate Form 2004

List the name(s) of the corporation's directors:

Name	Name
Name	Name

1. Entity Identification (continued)

b) Sole Proprietor/Partnerships/Associations/Unions

Full Name of Entity		Business Number or Quebec Enterprise Number
Registration Number (if applicable)	Jurisdiction (federal/provincial)	
Address (street number and name)		City
Province	Postal Code	Email Address
Describe principal business activity (if a holding company, describe the nature of businesses held)		

List the name(s) of the organization's principals/directors:

Name	Name
Name	Name

Please attach as applicable:

☐ Sole Proprietor:
Copy of business license or registration of business name
(Not required if name of company is the exact name of the proprietor)

☐ Union:
Copy of most recent collective agreement

☐ Association:
Copy of the bylaws, regulations, association agreement/nominate contract (PQ)

☐ Partnerships:
Copy of Partnership Agreement

1. Entity Identification (continued)

c) Not for Profit Organization (Incorporated or Non-Incorporated)

Full Name of Not for Profit Organization		
Incorporation Number (if applicable)	Jurisdiction (federal/provincial)	
Address (street number and name)	City	
Province	Postal Code	Email Address
Describe principal business activity (if a holding company, describe the nature of businesses held)		

I have attached one of the following (if applicable):

☐ a copy of articles of incorporation ☐ business license ☐ registration of business name or corporate search

Does the organization solicit charitable donations from the public? ☐ Yes ☐ No

Is the organization a charity registered with Canada Revenue Agency? ☐ Yes ☐ No

If yes, Registration Number _____

List the name(s) of the organization's directors:

Name	Name
Name	Name

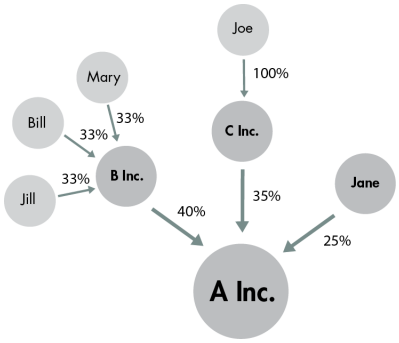
d) Estate or Trust

Complete the following information for all trustees/executors, beneficiaries and settlors of the Estate or Trust:

Select as applicable:	Name	Address
☐ Trustee/Executor ☐ Beneficiary ☐ Settlor		
☐ Trustee/Executor ☐ Beneficiary ☐ Settlor		
☐ Trustee/Executor ☐ Beneficiary ☐ Settlor		
☐ Trustee/Executor ☐ Beneficiary ☐ Settlor		
☐ Trustee/Executor ☐ Beneficiary ☐ Settlor		
☐ Trustee/Executor ☐ Beneficiary ☐ Settlor		
☐ Trustee/Executor ☐ Beneficiary ☐ Settlor		
☐ Trustee/Executor ☐ Beneficiary ☐ Settlor		
I have attached evidence of existence (choose at least one): ☐ Trust Agreement/Deed ☐ Will/Estate Documents		

2. Ownership Structure and Beneficial Ownership

If the Entity is complex with multiple layers of ownership, attach a chart showing the complete ownership structure. If any entity is owned by another entity, the chart should show all ownership interests up to the individuals who own or control the entity. As an example, if A Inc. owns the insurance policy:



A beneficial owner is an individual who owns or controls, directly or indirectly, 25% or more of the business/entity. Complete the following for each beneficial owner.

☐ No person owns or controls, directly or indirectly, 25% or more of the above business/entity.

Name (first, middle initial, last)		Residential Address (street number and name)	
% Control	City	Province	Postal Code

Name (first, middle initial, last)		Residential Address (street number and name)	
% Control	City	Province	Postal Code

Name (first, middle initial, last)		Residential Address (street number and name)	
% Control	City	Province	Postal Code

If you were unable to provide the information for any of the beneficial owners, please explain why:

_____

3. Declaration of Tax Residence

Check all of the options that apply to the entity.

☐ **The entity is a tax resident of Canada.** If the entity is a trust, give its trust account number.

Trust account number: T-_____

☐ **The entity is a tax resident of the United States.**

☐ **The entity is a tax resident of a jurisdiction other than Canada or the United States.**

Jurisdiction of tax residence: _____ Taxpayer identification number or functional equivalent: _____

If the entity does not have a TIN for a specific jurisdiction, give the reason using one of these choices:

☐ a) The entity will apply or has applied for a TIN but has not yet received it.

☐ b) The entity's jurisdiction of tax residence does not issue TINs to its residents.

☐ c) Other reason: _____

4. CLAIMANT'S INFORMATION

The following information is required to comply with Canadian legislation. In order for us to process your claim, please complete all of the following fields.

Name (please print)			S.I.N./ Tax Ident. (IRS) No.
Address		City or Town	Province
Phone Number		Postal or Zip Code	Country
Date of Birth (dd/mm/yyyy)	Relationship to Policy Owner	Occupation (job title and duties) – if not currently working, indicate former occupation	
In what capacity or by what do you claim the insurance (e.g. Named beneficiary, Executor or Assignee)?			Relationship to Deceased

How would you like the proceeds to be paid?

☐ Paid by cheque

The cheque will be mailed to Claimant's address unless an alternate address is provided:
Alternate Address:

☐ Deposit to Equitable® policy # _____

☐ Last survivor no payment at this time _____

Complete a new application with an advisor and attach it to this form. If you require an advisor please contact our Client Care team at 1 800 668 4095.

5. TRUSTEE INFORMATION

If there is a Trustee named on behalf of the Claimant, please complete the following fields.

Name (please print)		Email Address	S.I.N./ Tax Ident. (IRS) No.
Address		City or Town	Province
Phone Number		Postal or Zip Code	Country
Date of Birth (dd/mm/yyyy)	Relationship to Policy Owner	Occupation (job title and duties) – if not currently working, indicate former occupation	

6. IDENTIFY VERIFICATION

Equitable is required to verify the Claimant's identity (or the identity of the Trustee for the Claimant) on Universal Life and Whole Life policies where the death benefit is equal or greater than $10,000. If you meet these criteria (or you are unsure), please provide your consent to having your identity verified by a third party by checking the box below, and provide the identification documents as instructed.

☐ I consent to Equitable verifying my identity through a third-party service provider.

You are required to provide two forms of identification. Each of the documents must be from a different category below (that is, no more than one document from any one of the categories). The documents should be from a Canadian source unless otherwise indicated.

Category A (must include name and address)	**Category B** (must include name and date of birth)	**Category C** (must include name and account information)
Government issued photo identification (excluding provincial health cards) – different from Category B document	Government issued photo identification (excluding provincial health cards) – different from Category A document	Bank account statement
Benefits statement: Federal, Provincial, Territorial or Municipal	Birth Certificate	Loan account statement
Canada Pension Plan statement	Divorce documentation	Credit card statement
Provincial Vehicle Registration	Insurance company document (home, auto, life excluding Equitable)	Letter from bank, trust company or credit union confirming account
Municipal Property Tax Assessment	Permanent Resident Card	
Utility bill (e.g. hydro, phone, cable, etc.)	Citizenship Certificate	
Investment account statement (e.g. RRSP, securities account, excluding Equitable)	Investment account statement (e.g. RRSP, GIC, excluding Equitable)	
	Travel Visa issued by a foreign government	
	Temporary Driver's Licence (non-photo)	

SEND THE DOCUMENTS TO EQUITABLE

Legislation requires that the documents be valid and current. Please send copies of the documents without any alterations to Equitable using the delivery methods below:

If the documents are in paper format, do not send us the original. You can either mail in a copy with this completed form to the address indicated below, or scan them in and email the documents with this completed form. Electronic documents can be emailed with this completed form to IndividualClaims@equitable.ca.

Equitable
One Westmount Road North,
P.O. Box 1603 Stn. Waterloo
Waterloo ON N2J 4C7

Please note: Equitable cannot ensure the privacy and confidentiality of any information sent through the internet because e-mail may be vulnerable to interception. As a result, Equitable is not responsible for any loss or damages you may incur if your information is intercepted and misused. If you would prefer to submit your information by another means, please contact us at 1 800 668 4095.

7. CLAIMANT DECLARATION AND SIGNATURES

By signing below, you acknowledge and declare the following:

a) I declare that I am authorized to sign on behalf of the entity Claimant.

b) I certify that the information provided on this Statement is current, correct, and complete.

c) The personal information willingly provided by me to Equitable and held in their files will be used by Equitable for the purposes of claims processing and adjudication; improving and developing insurance and/or reinsurance related tools, processes, studies, algorithms, and products; and post-issue auditing. I understand and authorize that for the above purposes the personal information on file about me, the insured person, or this claim is accessible to, and may be exchanged with: authorized employees of, and relevant third parties retained by, Equitable; Equitable's sales distribution network; participating reinsurer(s); other insurance companies; investigative organizations; health care providers, medical professionals, and pharmacies; and any other person or party whom I authorize.

d) I acknowledge that personal information about me, the insured person, or this claim may be processed and stored outside of Canada and may therefore be subject to the laws of those jurisdictions. If this policy was issued in Quebec, my personal information will be stored outside of Quebec. Further details about Equitable's privacy practices and contact information for Equitable's Privacy Officer are available at www.equitable.ca.

e) I authorize all physicians and other persons who have attended the insured and all hospitals, institutions, and government authorities to provide Equitable all information in their possession or within their knowledge respecting the insured and to honour a copy of this authorization.

First Name	Middle initial	Last name	
Signature of signing officer or trustee		Title	Date (dd-mm-yyyy)

First Name	Middle initial	Last name	
Signature of signing officer or trustee		Title	Date (dd-mm-yyyy)

First Name	Middle initial	Last name	
Signature of signing officer or trustee		Title	Date (dd-mm-yyyy)

Dated at _____ this _____ day of _____

By providing this or other claim forms to the claimant, the Company does not admit to any liability or waive any of its rights.

A limitation period provision describes the time period in which you may commence a proceeding for recovery of policy benefits. This time period is set out in provincial insurance legislation or other legislation that applies to your claim.

Please note: Equitable cannot ensure the privacy and confidentiality of any information sent through the internet because e-mail may be vulnerable to interception. As a result, Equitable is not responsible for any loss or damages you may incur if your information is intercepted and misused. If you would prefer to submit your information by another means, please contact us at 1 800 668 4095.