



CLAIMANT'S STATEMENT – ENTITIES

Complete this form for claims if the claimant is an entity. For policies where the claimant is an individual, complete 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 statement should be completed by the assignee as well as the beneficiary. Payment will be made jointly to the beneficiary and the assignee.
2. Representative in Section 4 is the person completing the form on behalf of the entity claimant.
3. Verification of identity may be required to comply with Anti-Money Laundering legislation - see Section 1 for further instructions.

Policy numbers for this claim	Email address
Deceased's name (in full)	Province or State
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



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Please answer all the below questions:

Did the deceased have any other active life insurance policies at the time of death? Yes No Unknown

If yes, type of Insurance: _____ Amount: _____

To your knowledge, did the deceased ever smoke? 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? _____

1. CLAIMANT IDENTITY VERIFICATION

Equitable is required to verify the claimant's identity on Universal Life and Whole Life policies where the taxable death benefit is equal to or greater than \$10,000.

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)			
Does your business operate under any other names? Please list:			

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



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1. CLAIMANT IDENTITY VERIFICATION (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



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1. CLAIMANT IDENTITY VERIFICATION (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 the following records of provisions relating to the power to bind the organization (authority of officers to sign on behalf of the organization). 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

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, please provide the 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
<input type="checkbox"/> Trustee/Executor <input type="checkbox"/> Beneficiary <input type="checkbox"/> Settlor		
<input type="checkbox"/> Trustee/Executor <input type="checkbox"/> Beneficiary <input type="checkbox"/> Settlor		
<input type="checkbox"/> Trustee/Executor <input type="checkbox"/> Beneficiary <input type="checkbox"/> Settlor		
<input type="checkbox"/> Trustee/Executor <input type="checkbox"/> Beneficiary <input type="checkbox"/> Settlor		
<input type="checkbox"/> Trustee/Executor <input type="checkbox"/> Beneficiary <input type="checkbox"/> Settlor		

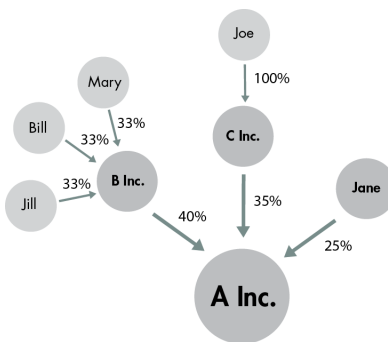
I have attached evidence of existence (choose at least one): Trust Agreement/Deed Will/Estate documents



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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, provide the 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: _____



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4. REPRESENTATIVE INFORMATION

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

Name (please print)		SIN/ TIN (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	
What's your role or connection to this insurance claim? (e.g. Executor, Assignee, or Signing Authority)?			Relationship to deceased
How would you like the proceeds to be paid?			
<input type="checkbox"/> Paid by cheque The cheque will be mailed to claimant's address unless an alternate address is provided: Alternate address: _____			
<input type="checkbox"/> Deposit to Equitable Policy # _____			
<input type="checkbox"/> Last survivor, no payment at this time _____			

5. REPRESENTATIVE IDENTITY VERIFICATION

Equitable is required to verify the Representative's identity on universal life and whole life policies where the taxable death benefit is equal to or greater than \$10,000. Please provide your consent to having your identity verified by a third party by checking the box below.

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



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6. REPRESENTATIVE 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 others related to the entity claimant, 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.

First name	Middle initial	Last name	
Signature of Representative		Title	Date (dd-mm-yyyy)

First name	Middle initial	Last name	
Signature of Representative		Title	Date (dd-mm-yyyy)

First name	Middle initial	Last name	
Signature of Representative		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.