



## CLAIMANT'S STATEMENT – TERM AND CRITICAL ILLNESS

Complete this form for claims under Term or Critical Illness policies. Please complete form 682WU for Whole Life or Universal Life policies. Additional forms can be found on EquiNet.

Number of each policy under which a claim is being made	
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

### 1. CLAIMANT INFORMATION

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	Date of Birth (dd/mm/yyyy)	Country	Postal or Zip Code
In what capacity or by what do you claim the insurance (e.g. Named beneficiary, Executor or Assignee)?			Relationship to Deceased
<p>How would you like the proceeds to be paid?</p> <input type="checkbox"/> Paid by cheque (default if no selection is made) The cheque will be mailed to Claimant's address unless an alternate address is provided: Alternate Address: _____			
<input type="checkbox"/> Deposit to Equitable Life policy # _____ <input type="checkbox"/> Deposit to a new Equitable Life savings policy Complete a new application with an advisor and attach it to this form. If you require an advisor please contact our Customer Service team at 1.800.668.4095.			



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### 2. TRUSTEE INFORMATION

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

Name (please print)		
Address	City or Town	Province
Phone number	Postal or Zip Code	Country

### 3. CLAIMANT'S DECLARATION

I certify that the information given in this Statement is true, correct and complete. I authorize all physicians and other persons who have attended the deceased and all hospitals, institutions and government authorities to provide Equitable Life of Canada all information in their possession or within their knowledge respecting the deceased and to honour a copy of this authorization.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_

Witness \_\_\_\_\_ Signature of Claimant \_\_\_\_\_

**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.**

### INSTRUCTIONS

Please feel free to contact our Head Office at 1.800.668.4095 for information or assistance in completing this Statement and providing proof of claim.

### COMPLETING THE CLAIMANT'S STATEMENT

- If the policy is payable to a named beneficiary or beneficiaries:
  - This statement should be completed by the named beneficiary, unless a minor. If there is more than one beneficiary, each beneficiary must complete a separate Statement.
  - If any named beneficiary is a minor, this Statement should be completed on behalf of the minor beneficiary by the guardian or other person authorized by law to deal with the minor's property.
  - If any named beneficiary is deceased, proof of death of such beneficiary must be provided.
- If the Policy is payable to the estate of the deceased:
  - The funds will be payable to the Estate of the deceased.
- 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.
- Claimant's Social Insurance No./Tax Ident. (IRS) No.:
  - This information is required from the claimant as it may be required to report any taxable income paid to the claimant. If the claimant has never been assigned a number, insert "No Number". If the estate of the deceased is the claimant, the deceased's Social Insurance Number should be inserted.

**Please note:** Equitable Life® 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 Life 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.