Equitable™
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CLAIMANT'S STATEMENT – TERM AND CRITICAL ILLNESS

Complete this form for claims under Term or Critical Illness policies if the Claimant is an individual. Complete form 682ENT for claims under any policy type where the claimant is an entity, or form 682WU for Whole Life or Universal Life policies where the Claimant is an individual. These forms can be found on EquiNet.

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

1. If the policy is payable to a named beneficiary or beneficiaries:
   a) 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.
   b) 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.
   c) If any named beneficiary is deceased, proof of death of such beneficiary must be provided.
2. If the Policy is payable to the estate of the deceased:
   a) The funds will be payable to the Estate of the deceased.
3. 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.
4. Claimant's Social Insurance No./Tax Ident. (IRS) No.:
   a) 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.

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

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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		Postal or Zip Code	Country
Date of Birth (dd/mm/yyyy)	Email Address	Occupation (job title and duties) - if not 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 direct deposit to the beneficiary(ies) bank account. Attach a void cheque or bank letter which outlines the account belongs to the beneficiary(ies) (Availability of payment via EFT may vary. If EFT is not available for this policy, a cheque will be issued and mailed to Claimant's address above)

☐ 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: _____

☐ Deposit to Equitable® policy # _____

☐ Deposit to a new Equitable savings policy
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.

☐ Last survivor no payment at this time.

2. TRUSTEE INFORMATION

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

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

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3. CLAIMANT'S DECLARATION

I certify that the information given in this Statement is true, correct, and complete.

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.

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.

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.

Dated at _____ this _____ day of _____

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.

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.