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EMPLOYER'S STATEMENT
Accidental Death or Dismemberment

Name of Policyholder:_____ Policy No.:_____

Employer's Name:_____

Address: _____

1. A) Name of the employee:_____

   B) Address:_____

2. Date of Birth(MM/DD/YY):_____

3. Occupation:_____ Date of Employment(MM/DD/YY):_____

   Please indicate: ☐Hourly ☐Salaried ☐Commissioned ☐Other explain):_____

4. Effective date of insurance coverage MM/DD/YY_____

   Insurance classification:_____ Amount of Insurance:_____

5. Date premium paid to(MM/DD/YY):_____ Salary on date last worked:_____

6. Was employee paid (please check): hourly ☐ weekly ☐ monthly ☐ annually ☐

7. Was the premium for this employee paid in Canadian $ ☐ or US $ ☐

8. Date employee last worked: _____ Reason employee did not return to work: _____

_____

9. Status of Employee on date last worked:

   ☐Active ☐Retired ☐Premium waiver for disability ☐Approved leave(provide explanation)

   ☐Other (explain) _____

10. Date of last benefit increase:_____
11. Is employee receiving Workers Compensation benefits?_____
12. Is employee receiving any other insurance? if yes, provide name of company and policy no.: _____
    .

IF CLAIM IS FOR DEPENDENT, PLEASE PROVIDE THE FOLLOWING

Dependent's name: _____ Date of Birth: (MM/DD/YY)_____

_____ _____
(Relationship) (Amount of Benefit)

EMPLOYER/ADMINISTRATOR SIGNATURE

"A person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim containing false, incomplete or misleading information, commits a fraudulent insurance act, which is a crime."

_____
Name of authorized personnel Signature of authorized personnel

_____
(Date signed) (City, Province) (Area code, Telephone number)

The furnishing of forms shall not be an admission of liability by the Company.