EMPLOYER / ADMINISTRATOR STATEMENT TO BE COMPLETED BY ADMINISTRATOR OF GROUP INSURANCE PLAN

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
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Toronto, Ontario M5L 1E2
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claims.A_H@chubb.com

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

SECTION I: PRIMARY INSURED/EMPLOYEE/MEMBER
(This section must be completed for all types of claims, including dependent claims)

Name of Primary Insured/Employee/Member:		**Employee ID:**
Name of Group Policyholder:		
Group Policy #	**Division #:**	**Certificate #:**
Name of Employer:	**Annual Salary: $**	**Occupation:**
Effective Date of Insurance:	**Amount of Insurance Coverage: $**	
Date Employed/Membership Effective Date:		
Actively Working? ☐ **Yes** ☐ **No**	**If no, please provide date last worked:**	
Has there ever been a previous claim submitted for this employee to Chubb or any other insurer? ☐ **Yes** ☐ **No**		
If "Yes", please provide details and dates:		
Date of Accident, Sickness or Death:		
Considered an employee/member as defined in the policy at time of death and/or loss? ☐ **Yes** ☐ **No**		
Reason for leaving work: ☐ **Disability** ☐ **Lay-Off** ☐ **Dismissed** ☐ **Quit** ☐ **Leave** ☐ **Retired** ☐ **N/A – Actively at Work**		
Did Accident, Sickness or Death arise out of, or in, the course of employment? ☐ **Yes** ☐ **No**		
If "Yes", please attach incident report and provide details:		

SECTION II: DEPENDENT INFORMATION
(This section must be completed for a dependent spouse or child)

Name of Dependent:	☐ **Spouse** ☐ **Child** ☐ **Other:**
Effective Date of Insurance Coverage:	**Amount of Insurance Coverage: $**
Has there been any previous claim submitted for this dependent to Chubb or any other insurer? ☐ **Yes** ☐ **No**	
If Yes, please provide details:	

SECTION III: BENEFICIARY INFORMATION
(Please complete for all death claims and attach beneficiary designation and change forms)

Beneficiary name (if applicable):	**Relationship:**
Address:	**Phone #: ( )**

SECTION IV: ADMINISTRATOR/EMPLOYER INFORMATION

Administrator's Name (please print):			
Company Name:			
Mailing Address:			
Province:		**City:**	**Postal Code:**
Phone #: ( )	**Fax #: ( )**	**Email Address:**	

Signature of Administrator ______________________________ Date ______________________________

NOTE: PLEASE ATTACH A COPY OF THE INCIDENT REPORT TO THIS STATEMENT.