INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

Public Service Management Insurance Plan

Claim for Death Benefit

Industrial Alliance Insurance and Financial Services Inc.

Group Policy No. G68-1400

A CLAIM CONSISTS OF FORM 5948 (PARTS 1 AND 2) AND FORM 5949 (PARTS 1, 2 AND 3).

Instructions to Claimant (Form 5948 – attached)

Please complete and sign Part 1 of the attached form. *If the claim is for an accidental death, the attending physician must complete Part 2.* Then forward the form directly to Industrial Alliance at the address below.

Group Life Claims
Industrial Alliance Insurance and Financial Services Inc.
522 University Avenue
Toronto, Ontario M5G 1Y7

You are responsible for any costs associated with the completion of the form.

Answer all questions fully.

If the proceeds are payable to the estate of the deceased, you must forward a certified copy of letters probate or administration with the attached form.

Please note: Form 5949 must also be completed.

The information you provide in the attached form is collected under the authority of the Treasury Board for the administration of the Public Service Management Insurance Plan. All information provided is strictly confidential.

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AVIS :
Cette formule est disponible en français

PART 1: TO BE COMPLETED BY THE CLAIMANT.

Claim is for benefits due upon death of: ☐ **Member** ☐ **Dependant**

Last name of Member	Given name	Member's date of birth Y M D	Member's Individual Agency No. (IAN)

Complete this line only if claim is for benefits due on a Dependant

Last name of Dependant	Given name	Relationship to Member	Dependant's date of birth Y M D

Cause of death (be specific)	Deceased's province of residence	Date of death Y M D

Last name of Claimant	Given name	Claimant's date of birth Y M D	Claimant's S.I.N. (required for income tax purposes)

Address of Claimant	Postal Code	Telephone No. of Claimant (optional)
		( )

Relationship of Claimant to Deceased	If proceeds payable to estate of Deceased, is a certified copy of letters probate or administration attached? ☐ Yes ☐ No

I (the Claimant) hereby authorize and direct any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau, the Deceased's employer or other organization, institution or person that has any records or knowledge of the Deceased or the Deceased's health to disclose fully to Industrial Alliance Insurance and Financial Services Inc. any such information regarding the Deceased. A photostatic or carbon copy of this authorization shall be as valid as the original.

Signature of Claimant _____ Date signed _____

PART 2: TO BE COMPLETED BY THE ATTENDING PHYSICIAN IF CLAIM IS FOR ACCIDENTAL DEATH

Last name of Patient	Given name	Date first consulted on account of injury Y M D	Date Patient last treated Y M D

Describe the exact nature, location and extent of injuries sustained

Name of attending physician (please print)

Address of attending physician (give number, street, city and province) Postal code

Signature of attending physician	Date Y M D

Form 5948 (05 05)

INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

Public Service Management Insurance Plan

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Industrial Alliance Insurance and Financial Services Inc.

Group Policy No. G68-1400

A CLAIM CONSISTS OF FORM 5949 (PARTS 1, 2 AND 3) AND FORM 5948 (PARTS 1 AND 2).

Instructions to Claimant (Form 5949 – attached)

Please complete and sign Part 1 of the attached form and then forward it to the member's personnel officer.

Answer all questions fully.

If you have not already submitted the member's, or if applicable, the dependant's death certificate to the Superannuation Directorate, you should attach it to this form.

Please note: Form 5948 must also be completed.

Instructions to Personnel Officer (Form 5949 – attached)

Please review Part 1 of the attached form to make certain that it has been fully completed. If the claim is for the death of the member you must complete and sign Part 2. Then forward the form to Superannuation Directorate, Public Works and Government Services Canada.

The information you provide in the attached form is collected under the authority of the Treasury Board for the administration of the Public Service Management Insurance Plan. All information provided is strictly confidential.

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INSURANCE AND FINANCIAL SERVICES INC.

Public Service Management Insurance Plan

Claim for Death Benefit

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Group Policy No. G68-1400

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Pay Office

PART 1: TO BE COMPLETED BY THE CLAIMANT.

Claim is for benefits due upon death of: ☐ **Member** ☐ **Dependant**

Last name of Member | Given name

Member's date of birth (Y M D) | Member's Individual Agency No. (IAN) | Date of death (if applicable) (Y M D)

Complete this line only if claim is for benefits due on a Dependant

Last name of Dependant | Given name | Relationship to Member | Date of birth (Y M D) | Date of death (Y M D)

Last name of Claimant | Given name

Address of Claimant | Postal Code | Telephone No. of Claimant (optional) ( )

Has the death certificate been submitted to the Superannuation Directorate? ☐Yes ☐ No
(If "No", please attach to this form)

I (the Claimant) hereby authorize and direct any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau, the Deceased's employer or other organization, institution or person that has any records or knowledge of the Deceased or the Deceased's health to disclose fully to Industrial Alliance Insurance and Financial Services Inc. any such information regarding the Deceased. A photostatic or carbon copy of this authorization shall be as valid as the original.

_____ Signature of Claimant

_____ Date signed

PART 2: TO BE COMPLETED BY PERSONNEL OFFICER, EMPLOYING DEPARTMENT FOR THE MEMBER.

Last day Member actively at work (Y M D) | Reason for interruption of employment (be specific) _____

For part-time Member
Assigned hours per week _____ | Effective date of assigned hours (Y M D) | Standard full-time hours per week

Name of Personnel Officer (please print) | Telephone No. of Personnel Officer ( )

Signature of Personnel Officer | Date (Y M D)

PART 3: TO BE COMPLETED BY THE SUPERANNUATION DIRECTORATE.

We hereby declare:

1. Insurance in force at the date of death in the following accounts

	Unreduced Amount	If Insurance has been reduced: Benefit Percentage	Date of/Age at Reduction	Reduced Amount
☐ Basic Life	_____	_____	_____	_____
☐ Supplementary Life	_____	_____	_____	_____
☐ Post Retirement Life Insurance	_____	_____	_____	_____

☐ A.D. & D. _____ units ☐ Dependant's coverage – spouse and children ☐Dependant's coverage – children only

2. We have proof that death occurred on _____ .
3. Proper proof of the date of the Member's birth has been received and the attached copies of the application card, change of name and beneficiary card(s) (if any) represent a complete and accurate extract from our files.
4. A claim for disability income benefit ☐ was ☐ was not submitted before death.

Remarks:
_____

Name of Authorized Representative (please print) | Signature of Authorized Representative | Date (Y M D)

Form 5949 (05 05)