Manitoba

Memorandum

Date: _____

From:
Department: _____
Address: _____
_____
_____ _____
Phone Number: _____
Contact Person: _____

To:
The Civil Service Superannuation Board
1200-444 St. Mary Avenue
Winnipeg MB R3C 3T1
Ph. 946-3200

Subject: ACCIDENTAL DISABLEMENT CLAIM - Policy G.2750

EMPLOYEE:

Last Name: _____ Given Names in Full: _____

Employee Number: _____ Social Insurance Number: _____

INSURANCE DATA:

a) Annual Salary Insurance Based on (rounded to nearest dollar): $ _____ (max. $25,000)

b) Class (maximum Class 3): _____

c) Insurance in Force: $ _____

We enclose the following forms:

___ Group Life Insurance and Dependents Insurance Appointment and Election Statement, Form 8001 OR Form 7425 (old card)

___ Application for Group Accidental Dismemberment Benefit, Form 1285

___ other (please specify): _____

_____
Authorized Signing Officer