

CLAIMS NOTIFICATION ACCIDENTAL DEATH & DISMEMBERMENT POLICY # 1HH85

Information required as soon as possible for claims involving **Accidental Death, Dismemberment, Loss of Use, Loss of Speech, Loss of Hearing, Loss of Eyesight or Paralysis:**

Employee Information

Employee's Last Name	Employee's First Name	Employee's SIN	
		-	-
Address		City	Province
Postal Code	Telephone Number	Email	Occupation

Claimant Information

Name of Claimant																																																	
Relationship to Employee	<input type="checkbox"/> Employee (Self) <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent																																																
Address																																																	
Date of Birth	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">y</td> <td style="text-align: center;">y</td> <td style="text-align: center;">y</td> <td style="text-align: center;">y</td> <td style="text-align: center;">m</td> <td style="text-align: center;">m</td> <td style="text-align: center;">d</td> <td style="text-align: center;">d</td> </tr> </table>									y	y	y	y	m	m	d	d																																
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Amount of Insurance																																																	
Please indicate your Optional AD&D Coverage	<input type="checkbox"/> Family - Spouse only <input type="checkbox"/> Single - Employee only <input type="checkbox"/> Family - Spouse and Children <input type="checkbox"/> Family - Children Only																																																
Date of Loss/Death																																																	
Nature of Loss (Life, Paralysis, Loss of Use of One Arm, etc.):																																																	
Description of Accident																																																	
In the event of death of the participant, please advise if he/she left behind any surviving family members:	Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Name of Spouse: _____ DoB: <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center;">y</td><td style="text-align: center;">y</td><td style="text-align: center;">y</td><td style="text-align: center;">y</td><td style="text-align: center;">m</td><td style="text-align: center;">m</td><td style="text-align: center;">d</td><td style="text-align: center;">d</td></tr></table> Dependent Child(ren): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Name of Child(ren): _____ DoB: <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center;">y</td><td style="text-align: center;">y</td><td style="text-align: center;">y</td><td style="text-align: center;">y</td><td style="text-align: center;">m</td><td style="text-align: center;">m</td><td style="text-align: center;">d</td><td style="text-align: center;">d</td></tr></table> _____ DoB: <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center;">y</td><td style="text-align: center;">y</td><td style="text-align: center;">y</td><td style="text-align: center;">y</td><td style="text-align: center;">m</td><td style="text-align: center;">m</td><td style="text-align: center;">d</td><td style="text-align: center;">d</td></tr></table>									y	y	y	y	m	m	d	d									y	y	y	y	m	m	d	d									y	y	y	y	m	m	d	d
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To be Completed by Employee

Date	
Signature	

To be Completed by Employer

Division Name	Email	Location	Division Number																
Telephone No.:	Effective Date of Coverage <table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">y</td> <td style="text-align: center;">y</td> <td style="text-align: center;">y</td> <td style="text-align: center;">y</td> <td style="text-align: center;">m</td> <td style="text-align: center;">m</td> <td style="text-align: center;">d</td> <td style="text-align: center;">d</td> </tr> </table>									y	y	y	y	m	m	d	d	Certificate No. (if known)	
y	y	y	y	m	m	d	d												
Name of Contact Person Please Print):	Date _____																		
Signature of Contact Person _____																			

Please forward the original to Group Benefits Solutions, Health Association Nova Scotia, 2 Dartmouth Road, Bedford NS B4A 2K7.