HEALTH ASSOCIATION NOVA SCOTIA

CENTRAL ZONE CLAIMS NOTIFICATION ACCIDENTAL DEATH & DISMEMBERMENT POLICY # IC280 & 2IC285

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

Last Name	First Name	Middle Initial	Employee's ID

Address		City	Province
Postal Code	Telephone Number	Email	Occupation

Claimant Information

Name of Claimant	
Relationship to Employee	☐ Employee (Self) ☐ Spouse ☐ Dependent
Address	
Date of Birth	MM DD YYYY
Amount of Insurance	
Benefit Type	☐ Basic AD&D (Policy #IC280) *Employee Only* ☐ Optional AD&D (Policy #2IC285)
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: ☐ Yes ☐ No ☐ Unknown Name of Spouse: _____ DoB: MM DD YYYY Dependent Child(ren): ☐ Yes ☐ No ☐ Unknown Name of Child(ren): _____ DoB: _____ DoB: _____ DoB: MM DD Y YYY

To be Completed by Employee

Date	
Signature of Employee	

To be Completed by Employer

Division Name	Certificate No. (if known)	Location
Telephone No.:	Email	Division Number
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.