HEALTH ASSOCIATION NOVA SCOTIA

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

Last Name	First Name	Middle Initial	Employee's CERT

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	
Please indicate your Optional AD&D Coverage	☐ Family - Spouse only ☐ Single - Employee only ☐ Family - Spouse and Children ☐ 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: ☐ 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.