OTIP Group Life and Disability Claims
125 Northfield Drive West
PO Box 218
Waterloo ON N2J 3Z9
1.800.267.6847 | www.otip.com

Life Claim Kit

Reset

INSTRUCTIONS FOR COMPLETION AND REQUIREMENTS

Insured Member Life Claim *(please print all answers)*

Complete pages 2-4 of this form

• Claimant completes and signs pages 2-4

Please check for the following requirements:

Proceeds UNDER $300,000

☐ Original or notarized copy of Funeral Director's Statement of Death, and newspaper death report or obituary notice (if available)

OR

☐ Attending Physician's Statement (Life Claim), pages 5-6 of this form

Proceeds $300,000 and OVER

☐ Original or notarized copy of Provincial Death Certificate

OR

☐ Attending Physician's Statement (Life Claim), pages 5-6 of this form

Accidental Death

☐ Attending Physician's or Coroner's Statement for Accidental Death (pages 7-8 of this form)

Dependant Life Claim *(please print all answers)*

Complete pages 2-4 of this form

• Insured member completes and signs pages 2-4

Please check for the following requirements:

Proceeds UNDER $300,000

☐ Original or notarized copy of Funeral Director's Statement of Death, and newspaper death report or obituary notice (if available)

OR

☐ Original or notarized copy of Provincial Death Certificate

Proceeds $300,000 and OVER

☐ Original or notarized copy of Provincial Death Certificate

OR

☐ Attending Physician's Statement (Life Claim), pages 5-6 of this form

Accidental Death

☐ Attending Physician's or Coroner's Statement for Accidental Death (pages 7-8 of this form)

MISCELLANEOUS REQUIREMENTS

Payments to minor beneficiary

☐ ORIGINAL or NOTARIZED copy of Court Appointment of Guardianship of the Estate of the Minor

Payments to estate

☐ ORIGINAL or NOTARIZED copy of the Probated Will or Letters of Administration for proceeds $50,000 and over

Beneficiary has died before the insured member

☐ ORIGINAL or NOTARIZED/CERTIFIED copy of the deceased Beneficiary's Proof of Death

MAIL COMPLETED FORMS TO OTIP:

OTIP Group Life and Disability Claims
125 Northfield Drive West
PO Box 218
Waterloo ON N2J 3Z9

If you have any questions, please contact OTIP Group Life and Disability Claims at 1-800-267-6847.

CLAIMANTS' STATEMENT

Fax completed forms to 1-877-205-6847 or mail to OTIP:

OTIP Group Life and Disability Claims
125 Northfield Drive West
PO Box 218
Waterloo ON N2J 3Z9

If you have any questions, please contact OTIP Group Life and Disability Claims at 1-800-267-6847.

To be completed by the person(s) claiming the Life Insurance Benefit. Please print.

1. Deceased Identification

Name: First _____ Initial _____ Last _____

Policy Number: _____ Location (Class): _____

Date of Death: *(mm/dd/yyyy)* _____ Cause of Death: _____

Relationship to Insured Member: ☐ Insured Member ☐ Spouse ☐ Child

2. If Insured Member was disabled prior to death, was any claim for disability benefits filed?

☐ Yes ☐ No

If yes, please provide claim number, and name of insurance company:

Claim Number: _____ Insurance Company: _____

3. If death was accidental, please complete the following questions:

Date of Accident: *(mm/dd/yyyy)* _____

Where did the accident happen? ☐ Home ☐ Work ☐ Elsewhere (Specify) _____

If motor vehicle accident, was the deceased the driver? ☐ Yes ☐ No

How did the accident happen? Please give the complete description. (If insufficient space, please attach a separate sheet to this form.)

_____

_____

_____

_____

_____

CLAIMANTS' STATEMENT (CONTINUED)

Claimant(s) Information *(To be completed by each Claimant)*

1. Claimant's Identification

Name: First _____ Initial _____ Last _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Social Insurance Number: _____

Relationship to the deceased (Named Beneficiary, Trustee, Executor, etc.) _____

Date of Birth (If over legal age, state "over legal age"): *(mm/dd/yyyy)* _____

2. Claimant's Identification *(if more than one Claimant)*

Name: First _____ Initial _____ Last _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Social Insurance Number: _____

Relationship to the deceased (Named Beneficiary, Trustee, Executor, etc.) _____

Date of Birth (If over legal age, state "over legal age"): *(mm/dd/yyyy)* _____

3. Claimant's Identification *(if more than two Claimants)*

Name: First _____ Initial _____ Last _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Social Insurance Number: _____

Relationship to the deceased (Named Beneficiary, Trustee, Executor, etc.) _____

Date of Birth (If over legal age, state "over legal age"): *(mm/dd/yyyy)* _____

CLAIMANTS' STATEMENT (CONTINUED)

Declaration (To be signed by each Claimant)

I certify that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge.
I agree that my claim may be denied as a result of my providing false, incomplete, or misleading information.

I hereby claim the life insurance proceeds payable as a result of the death of the deceased, _____ .

I understand that OTIP and its insurer will investigate this claim and may require information related to the deceased's health, employment, police investigations, and autopsy, or coroner's inquest reports (collectively referred to in this authorization as "Information").

I authorize any person or organization who has Information pertaining to this claim, including any employer, plan administrator, plan sponsor, health care professional, health care institution and any other medically-related facility, insurer, police, coroner and investigative agency, to release and exchange Information requested by OTIP and its insurer for the purposes of benefits plan administration and investigation and management of this claim ("Purposes").

I authorize OTIP, its insurer and their reinsurers and/or service providers to collect, to use, to maintain and to disclose to the persons or organizations listed above and/or each other any Information needed for the Purposes.

I authorize the use of my Social Insurance Number for tax reporting.

I agree that a photocopy or electronic version of this authorization is valid.

I understand that OTIP's Privacy Policy is available at www.otip.com or by request.

Claimant's Signature: _____ **Date:** ***(mm/dd/yyyy)*** _____

Claimant's Signature: _____ **Date:** ***(mm/dd/yyyy)*** _____

Claimant's Signature: _____ **Date:** ***(mm/dd/yyyy)*** _____

Any Information provided to or collected by OTIP in accordance with this authorization, will be kept in a benefits health file. Access to the Information will be limited to:

- OTIP employees, OTIP's representatives, OTIP's insurer and their reinsurers and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

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Attending Physician's Statement (Life Claim)

The Claimant is PERSONALLY responsible for ALL EXPENSES RELATED TO the completion of this form.

PLEASE COMPLETE THE FOLLOWING INFORMATION

1. Deceased Identification

Name: First _____ Initial _____ Last _____

Date of Death: *(mm/dd/yyyy)* _____ Residence at Death: _____

Place of Death (If Hospital or Institution, Give Name): _____

_____

Age at Death or Date of Birth: *(mm/dd/yyyy)* _____

2. Cause of Death

(Enter only ONE cause for each of A, B and C)	**Interval between onset and death:**
A) **Disease or condition directly leading to death** (This does not mean the mode of dying such as Heart Failure, Asthenia, etc. It means the disease, injury or complication which caused death): **Antecedent causes** (Morbid conditions, if any, giving rise to the above cause. State the underlying cause last):	A)
B) Due to or as a consequence of:	B)
C) Due to or as a consequence of:	C)

Other significant conditions (contributing to the death but not related to the disease or condition causing death):

_____

_____

_____

3. Medical History of Deceased

Date of first attendance in last illness: *(mm/dd/yyyy)* _____

Date of last attendance in last illness: *(mm/dd/yyyy)* _____

If death was due to accident, homicide or suicide, specify which. Describe briefly:

_____

_____

Was an inquest held? ☐ Yes ☐ No

Was an autopsy performed? ☐ Yes ☐ No

If so, by whom and with what findings?

_____

_____

Have you treated or advised the deceased during the last 3 years, prior to last illness? ☐ Yes ☐ No

Did the deceased, to your knowledge, receive treatment during the last 3 years from any other physician, or in a hospital or institution? ☐ Yes ☐ No

If "Yes" to either question, please furnish the following:

Name of Physician: _____

Address: _____

Nature of illness or injury: _____ Date: *(mm/dd/yyyy)* _____

4. Declaration

I certify that the information in this form, and any further verbal or written statement provided by me in the future concerning this claim, is true and complete to the best of my knowledge. **I understand** that the information in this form will be kept in a benefits health file relating to this claim and might be accessible by third parties to whom authorized access has been granted. **I acknowledge and agree** that by signing this document I consent to the unedited disclosure of any information contained herein, to OTIP and its insurer.

Attending Physician's Full Name: _____

Degree or Qualification: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Attending Physician's Signature: _____ Date: *(mm/dd/yyyy)* _____

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Attending Physician's or Coroner's Statement for Accidental Death

The Claimant is PERSONALLY responsible for ALL EXPENSES RELATED TO the completion of this form.

PLEASE COMPLETE THE FOLLOWING INFORMATION

1. Deceased Identification

   Name: First _____ Initial _____ Last _____

   Date of Injury: *(mm/dd/yyyy)*_____ Date of Death: *(mm/dd/yyyy)* _____

2. What was the precise nature and extent of the injury? _____

3. What was the primary or immediate cause of death? _____

4. Was the deceased ever treated for a similar condition? ☐ Yes ☐ No

   If "**Yes**", where and by whom? _____

5. Was there any contributing or remote causes of death? ☐ Yes ☐ No

   If "**Yes**," what were they? _____

6. Was the injury, described above, by itself and independent of all causes, sufficient to cause of death? ☐ Yes ☐ No

   If "**No**," please explain fully. _____

ATTENDING PHYSICIAN'S OR CORONER'S STATEMENT FOR ACCIDENTAL DEATH (CONTINUED)

7. At the time of the injury, was the deceased under the influence of alcohol or narcotic drugs? ☐ Yes ☐ No

   If "**Yes**," please show blood alcohol content and/or type of drug.

   Blood Alcohol Content: _____ Type of Drug: _____

8. Was an autopsy performed? ☐ Yes ☐ No

9. Declaration

   I certify that the information in this form, and any further verbal or written statement provided by me in the future concerning this claim, is true and complete to the best of my knowledge. **I understand** that the information in this form will be kept in a benefits health file relating to this claim and might be accessible by third parties to whom authorized access has been granted. **I acknowledge and agree** that by signing this document I consent to the unedited disclosure of any information contained herein, to OTIP and its insurer.

   Attending Physician's or Coroner's Full Name: _____

   Degree or Qualification: _____

   Address: _____

   City: _____ Province: _____ Postal Code: _____

   Attending Physician's or Coroner's Signature: _____ Date: *(mm/dd/yyyy)* _____