Guardian Life Centre, 12 Trafalgar Road, P.O. Box 408, Kingston 5

EMPLOYEE BENEFITS ADMINISTRATION

CLAIM FORM

EB 236

CLAIM FORM – GROUP LIFE & ACCIDENTAL & DISMEMBERMENT (NOTICE OF CLAIM should be given within 30 days following the death or accident).

POLICYHOLDER/PROPOSER: ______________________________

[1a]**GROUP NUMBER:** ______________________ [1b]**MEMBER NUMBER:** ______________

[3]**MEMBER'S NAME IN FULL:**______________________________

DATE OF BIRTH: Day_____ Month ____ Year________ [2] **T.R.N. (MEMBER):** ______________

DATE OF CLAIM: ______________________________

TYPE OF CLAIM:

- Death ☐
- Disability/Dismemberment ☐
- Loss of Income ☐

Documents attached/enclosed:

- Physician Statement (Personal Accident) ☐
- Death Certificate ☐
- Police Report ☐
- Post Mortem Examination Report ☐
- Coroner's Court Report ☐
- Medical Report ☐
- Order for Burial ☐
- Funeral Home/Undertaker bill ☐
- Other (*Please State*) ☐ ______________________________

Special Request:______________________________

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Signature of Authorized Person: ______________________________ Date: ______________

For Official Use: Index by Group Number, Member Number, TRN and Name of Member