



Public Service Management Insurance Plan
Claim for Accidental Dismemberment Benefit
Industrial Alliance Insurance and Financial Services Inc.

Group Policy No. G68-1400

A CLAIM CONSISTS OF FORM 5954 (PARTS 1 AND 2) AND FORM 5955 (PARTS 1, 2 AND 3).

Instructions to Member (Form 5954 – attached)

Please complete and sign Part 1 of the attached form. *If the claim is for a dependant who is 18 years of age or older, the dependant must also sign.* Then forward the form to the attending physician. Once the entire form has been completed it should be sent directly to Industrial Alliance at the address below.

Group Life Claims
Industrial Alliance Insurance and Financial Services Inc.
522 University Avenue
Toronto, Ontario M5G 1Y7

You are responsible for any costs associated with the completion of the form.

Answer all questions fully. If there is insufficient space for your answers, use separate sheets and attach them to the form.

Please note: Form 5955 must also be completed.

The information you provide in the attached form is collected under the authority of the Treasury Board for the administration of the Public Service Management Insurance Plan. All information provided is strictly confidential.



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A CLAIM CONSISTS OF FORM 5955 (PARTS 1, 2 AND 3) AND FORM 5954 (PARTS 1 AND 2).

Instructions to Member (Form 5955 – attached)

Please complete and sign Part 1 of the attached form. *If the claim is for a dependant who is 18 years of age or older, the dependant must also sign.* Then forward the form to your personnel officer.

Answer all questions fully. If there is insufficient space for your answers, use separate sheets and attach them to the form.

Please note: Form 5954 must also be completed.

Instructions to Personnel Officer (Form 5955 – attached)

Please review Part 1 of the attached form to make certain that it has been fully completed. You must complete and sign Part 2. Then forward the form to Superannuation Directorate, Public Works and Government Services Canada.

The information you provide in the attached form is collected under the authority of the Treasury Board for the administration of the Public Service Management Insurance Plan. All information provided is strictly confidential.



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AVIS :
 Cette formule est
 disponible en français

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PART 1: TO BE COMPLETED BY THE MEMBER.

Claim is for benefit on: <input type="checkbox"/> Member <input type="checkbox"/> Dependant			
Last name of Member		Given name	Member's date of birth Y M D
Member's address			Member's Individual Agency No. (IAN)
Member's address		Postal Code	Member's Telephone No. ()
Complete this line only if claim is for benefit due on a Dependant			
Last name of Dependant		Given name	Relationship to Member
Date accident occurred Y M D		Where accident occurred	Dependant's date of birth Y M D
<p>I certify that the above is true and complete and hereby authorize the release to Industrial Alliance Insurance and Financial Services Inc. of any information requested with respect to this claim. It is expressly agreed that any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau, my employer or any other organization, institution or person that has any records or knowledge of my or, if applicable, my dependant's health and medical history to give to Industrial Alliance Insurance and Financial Services Inc. any such information. I also consent to a personal investigation of myself, or, if applicable, my dependant. A photostatic or carbon copy of this authorization shall be as valid as the original.</p>			
_____		Signature of Member	_____
_____		Signature of Dependant (if 18 years of age or older)	Date signed
_____		Signature of Dependant (if 18 years of age or older)	Date signed

PART 2: TO BE COMPLETED BY THE PERSONNEL OFFICER.

Member is: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		For part-time Member Assigned hours per week _____	Effective date of assigned hours Y M D	Standard full-time hours per week
Date Member last actively at work prior to accident Y M D		Reason for discontinued work _____		
Date Member returned to work Y M D		Anticipated date of return to work Y M D		
Name of Personnel Officer (please print)			Telephone No. of Personnel Officer ()	
Signature of Personnel Officer			Date Y M D	

PART 3: TO BE COMPLETED BY THE SUPERANNUATION DIRECTORATE.

We hereby declare:		
1. Insurance in force at the date of the accident: <input type="checkbox"/> A.D. & D. _____ units <input type="checkbox"/> Dependant's coverage – spouse and children <input type="checkbox"/> Dependant's coverage – children only		
2. Proper proof of the date of the Member's birth has been received and the attached copies of the application card, change of name and beneficiary card(s) (if any) represent a complete and accurate extract from our files.		
Remarks: _____ _____ _____		
Name of Authorized Representative (please print)	Signature of Authorized Representative	Date Y M D