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.

AVIS :
Cette formule est disponible en français

Public Service Management Insurance Plan

Claim for Accidental Dismemberment Benefit

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Group Policy No. G68-1400

PART 1: TO BE COMPLETED BY THE MEMBER.

Claim is for benefit on: ☐ **Member** ☐ **Dependant**

Last name of Member		Given name	
Member's date of birth Y M D	Member's Social Insurance Number (required for income tax purposes)		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	Dependant's date of birth Y M D

Give a brief description of the accident

Date accident occurred Y M D	Where accident occurred	Date injury first treated by physician Y M D

Name of physician injury treated by. If more than one, please list.	Address of physician(s)
Name of hospital where confined due to injury. If more than one, please list.	Date of hospitalization. If more than one period of hospitalization, please list. From Y M D to Y M D

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.

Signature of Member | Date signed

Signature of Dependant (if 18 years of age or older) | Date signed

PART 2: TO BE COMPLETED BY THE ATTENDING PHYSICIAN.

Last name of Patient	Given name	Date first consulted on account of injury Y M D	Date Patient last treated Y M D

1. Describe the exact nature, location and extent of injuries sustained:

2. If the accident caused the loss of an arm, hand, leg or foot or any part thereof, indicate the level of amputation.

Date of amputation
Y M D

PART 2: TO BE COMPLETED BY THE ATTENDING PHYSICIAN. (CON'T)

3. If the accident caused Quadriplegia, Paraplegia or Hemiplegia, date paralysis occurred.
   Y M D

4. If the accident resulted in total and irrecoverable loss of sight of either or both eyes, date on which such loss occurred.
   Y M D

   (a) If the accident necessitated removal of either or both eyes, date of removal.
   Y M D

   (b) What was the vision in each eye prior to the accident?
   Left: __________ Right: __________

   (c) What percentage of vision, if any, remains in each eye?
   Left: __________ Right: __________

5. If the accident resulted in total and irrecoverable loss of speech, date such loss occurred.
   Y M D

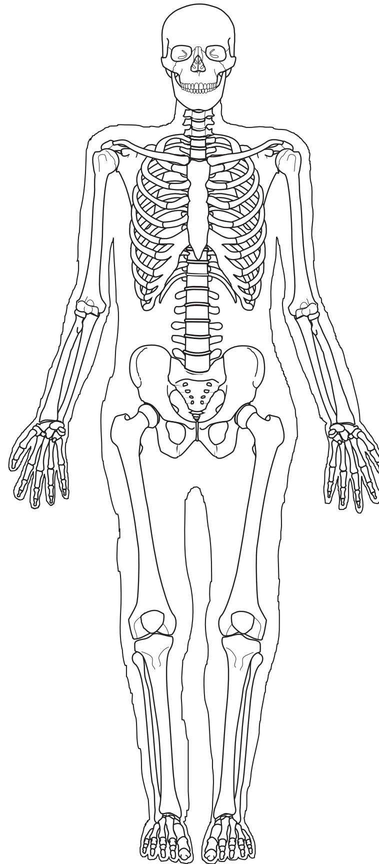
6. If the accident resulted in total and irrecoverable loss of hearing in both ears, date such loss occurred.
   Y M D

7. Was the injury described solely responsible for the loss? ☐Yes ☐No
   If "No", please give particulars of any contributing cause or causes.

   ____

   ____

Please indicate on chart at what level amputation was made.



Attending Physician's name (please print)	Telephone No. of Attending Physician ( )
Address of Attending Physician	Postal Code
Attending Physician's signature	Date Y M D

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 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.

Public Service Management Insurance Plan

Claim for Accidental Dismemberment Benefit

Industrial Alliance Insurance and Financial Services Inc.

Group Policy No. G68-1400

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PART 1: TO BE COMPLETED BY THE MEMBER.

Claim is for benefit on: ☐ **Member** ☐ **Dependant**

Last name of Member	Given name	Member's date of birth Y / M / D	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	Dependant's date of birth Y / M / D

Date accident occurred Y / M / D	Where accident occurred

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.

Signature of Member ____________ 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: ☐ Full-time ☐ 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:
   ☐ A.D. & D. ______ units ☐ Dependant's coverage – spouse and children ☐ 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

Form 5955 (05 05)