Industrial Alliance Insurance and Financial Services Inc.
iA Special Markets (Claims Department)
400–988 Broadway W,
PO Box 5900, Vancouver, BC V6B 5H6

Telephone 1 800-266-5667
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Website ia.ca

Certificate of Employer or Superior Officer — Death Claim

This statement is to be furnished without expense to the Company.

Name of Employee | Policy Number(s) | Certificate Number

Street Address of Last Residence | City | Province | Postal Code

Email Address | Phone Number

Amount(s) of Principal Sum(s) | Employee Classification as Outlined in Policy | Effective Date of Coverage (D D / M M / Y Y Y Y)

Date of Employment (D D / M M / Y Y Y Y) | Date of of last increase in insurance (D D / M M / Y Y Y Y) | Date Premium Paid To (D D / M M / Y Y Y Y) | Date last actively at work (D D / M M / Y Y Y Y)

If date last at work was other than date of accident/sickness, give reason for absence from work

If injured on duty, what work was the Employee engaged in at the time of the accident?

On what date did accident/sickness occur? (D D / M M / Y Y Y Y) | Place of accident? | Date of Death (D D / M M / Y Y Y Y)

As at date last actively at work give Employee's:

Salary $ | Occupation

This employee is/was one of our Insured Employees at the time of the accident ☐ Yes ☐ No

Complete when accident/sickness results in death, and Insured Person is other than Employee.

Name of Deceased | Date of Birth (D D / M M / Y Y Y Y)

Deceased Was:

- ☐ cohabiting spouse
- ☐ dependent child

At time of accident/sickness the Employee

- ☐ with no dependent children
- ☐ has dependent child(ren) but no spouse
- ☐ with dependent child(ren)

Employer's Name

Street Address

City | Province | Postal Code

Email Address | Phone Number

Authorized Representative (Please Print) | Title of Authorized Representative

Authorized Signature | Date Signed (D D / M M / Y Y Y Y)