CUMIS Life Insurance Company
P.O. 5065, 151 North Service Rd., Burlington, Ontario L7R 4C2
Tel: (905) 632-1221 / 1-800-263-9120 Fax: (905) 632-4886 / 1-800-897-7065
Service en français
Tél: 1-800-361-3936 Télécopieur: 1-800-897-7065

CUMIS®

INITIAL CLAIM FORM FOR LOSS OF EMPLOYMENT BENEFITS

PART 1 - AUTHORIZATION TO BE COMPLETED BY MEMBER

CLAIM NO. _____

AUTHORIZATION FOR RELEASE OF MEDICAL AND EMPLOYMENT INFORMATION - I authorize any Physician, Hospital, Insurer, Employer or any other organization or person having any records, data or information concerning me to furnish such records, data or information as may be requested by CUMIS Life Insurance Company.

I understand that the personal information furnished herein will be used by CUMIS to administer my claim, and for such other lawful purposes in accordance with applicable federal and provincial laws, as may apply.

A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF MEMBER _____ AREA CODE - TELEPHONE NO. _____ MONTH/DAY/YEAR _____

PART 2 - STATEMENT TO BE COMPLETED BY EMPLOYER

Employer Name _____ Phone No. (_____) _____ Fax No. (____) _____
Area Code *Area Code*

Address _____
Number & Street *City* *Province* *Postal Code*

Office Hours _____

1. Employee's Name _____
Last *Initial* *First*

2. Date employment commenced with your company month _____ day _____ year _____

3. Job title as of date last physically at work _____

Date hired for this position: month _____ day _____ year _____

Briefly describe duties _____

_____

Normal number of hours worked per week _____ Annual Salary _____
(Excluding overtime) *(Excluding overtime, shift bonuses, etc.)*

4. Was employee's position classified as "seasonal" employment? ☐ Yes ☐ No If "Yes", dates when work not available _____ to _____
month/day/year *month/day/year*

5. Was employee's position classified as "contract" employment? ☐ Yes ☐ No If "Yes", dates when work contract ran: from _____ to _____
month/day/year *month/day/year*

6. Date employee first advised job no longer available month _____ day _____ year _____

7. Effective date when employee's job no longer available month _____ day _____ year _____

8. Reason for loss of employee's job _____

9. Is there any possibility of a recall? ☐ Yes ☐ No If "Yes", when might recall be made? month _____ day _____ year _____

10. Date when RECORD OF EMPLOYMENT provided _____ **PLEASE ATTACH A COPY**
month / day / year

11. Was a severance allowance provided? ☐ Yes ☐ No If "Yes", amount and date to which severance provides benefits

_____

I hereby certify that the above information is correct.

Signature _____ Title _____
(Mr., Mrs., Miss, Ms.)

Print name _____ Date _____
month / day / year

The information furnished herein will be used by CUMIS for claims administration purposes, and for such other lawful purposes in accordance with applicable federal and provincial laws, as may apply.

EP022 0408

CUMIS® is a trademark of CUMIS Insurance Society, Inc. and is used under licence. 0408