iA Financial Group

Return to:
Life and Health Claims Dept., Special Markets Solutions
400–988 Broadway W, PO Box 5900
Vancouver, BC V6B 5H6

Certificate of Policyholder

Please print in ink

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

Name of Insured | Policy Number(s) | Claim Number

Address
Street

City | Province | Postal Code | Effective Date of Insurance (D D / M M / Y Y Y Y)

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

On what date did accident/sickness occur? (D D / M M / Y Y Y Y)

Where?

If an accident, give details of how it happened.

As at date last actively at work give Insured's occupation:

In what capacity is Insured associated with the Policyholder (i.e. Director, Trustee, etc.)?

Policyholder Name

Street Address

City | Province | Postal Code

Phone Number

Authorized Representative (Please Print)

Date Signed (D D / M M / Y Y Y Y)

Authorized Signature