

Please answer all questions fully – it helps us to provide better service

Please complete this form in ink (please print) and return to:

 Western Life Assurance Company
 P.O. Box 3300
 Winnipeg, MB R3C 5S2

Early filing of the Notice of Claim will help expedite the claims process.

 Policy Number _____ Date notice reported to Western Life D M Y

Employer / Policyholder _____

Address _____

 Employee / Member _____ Date of Birth D M Y

Home Address _____

Occupation _____ Class / Division _____

Name of person reporting loss _____

Relationship to Employee / Member

 Employer / Policyholder
 Broker
 Insured
 Beneficiary
 Other _____

Email Address _____ Telephone No. () _____

 Ill / Injured / Deceased Insured _____ Date of Birth D M Y

Relationship to Employee / Member _____

Home Address (if different from Employee / Member) _____

Benefit Claiming Under _____

 Date of Loss / Death / Illness D M Y

Nature of Claim (Illness, Injury, Life, Paralysis, Loss of Use of One Arm, etc.) _____

 Date of Accident D M Y Place of Accident _____

Circumstances of Accident _____

Sum Insured \$ _____ Beneficiary _____

In the event of death of Employee / Member, please advise if he/she left:

 Spouse: Yes No Unknown
 Dependent Child(ren): Yes No Unknown
 If "Yes"

 Name of spouse _____ Date of Birth D M Y

 Name of child(ren) _____ Date of Birth D M Y

(if space is insufficient, please use a separate sheet of paper)

Send claim forms to the attention of _____

Email address _____

Company Name (if applicable) _____

Address _____