ACE INA Insurance
ACE INA Life Insurance
1400 – 25 York Street
Toronto, Ontario M5J 2V5
Telephone: 416-594-2627 1-877-772-7797

CRITICAL ILLNESS
EMPLOYER / ADMINISTRATOR STATEMENT
TO BE COMPLETED BY ADMINISTRATOR OF
GROUP INSURANCE PLAN

Section I: Primary Insured/Employee/Member

(This section must be completed for all types of claims, including dependent claims)

Name of Primary Insured/Employee/Member:	Employee ID #
Name of Group Policyholder:	
Group Policy #	Certificate #
Name of Employer:	Occupation:
Effective Date of Insurance:	
Date Employed/Membership Effective Date:	
Amount of Insurance Coverage: Mandatory Critical Illness: $	
Optional Critical Illness*: $	
Actively Working? ☐ Yes ☐ No	If no, please provide date last worked:
Has there ever been a previous claim submitted for this employee to ACE or any other insurer? ☐ Yes ☐ No	
If yes, please provide details and dates:	
Date of Sickness or Death:	
Considered an employee/member as defined in the policy at time of death and/or loss? ☐ Yes ☐ No	
Reason for leaving work ☐ Disability ☐ Lay-off ☐ Dismissed ☐ Quit ☐ Leave ☐ Retired ☐ N/A – Actively at work	
Did Sickness or Death arise out of, or in, the course of employment? ☐ Yes ☐ No	
If Yes, please attach incident report and provide details:	

Section II: Dependent Information

(This section must be completed for a dependent spouse or child claim)

Name of Dependent:
☐ Spouse ☐ Child ☐ Other:
Effective Date of Insurance Coverage:
Amount of Insurance Coverage: Mandatory Critical Illness: $
Optional Critical Illness*: $
Has there ever been any previous claim submitted for this dependent to ACE or any other insurer? ☐ Yes ☐ No
If Yes, please provide details:

Section III: Administrator/Employer Information

(Please print clearly)

Administrator's Name (please print)	
Signature of Administrator	Date
Company Name	
Mailing Address	City
Province	Postal Code
Phone # ( )	Fax # ( )
Email Address (MANDATORY):	

NOTE: PLEASE ATTACH A COPY/PRINT OUT OF THE BENEFIT STATEMENT

**Must attach a copy of the Enrollment info.*