Notice of Long-Term Disability (LTD) Claim Form

Please answer all questions carefully and completely as this will assist us in providing you the best possible service

This form should be completed in ink (please print) and mailed, faxed or emailed to:

The Wawanesa Life Insurance Company c/o
Unistar Special Risks Inc. Attn: Claims
#105, 1209 – 59th Avenue SE
Calgary, AB T2H 2P6

Email: claims@unistarinc.ca
Fax #: 1-800-364-0754

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

Employer / Policyholder: _____ Date of Hire: _____(dd/mm/yy)

Employer/Policyholder Address: _____, _____ _____
Street *City, Province* *Postal Code*

Employer/Policyholder Contact Name: _____

Employer Email Address: _____ Telephone No.: ( )_____

Employee Name: _____ Date of Birth: _____(dd/mm/yy)

Employee's Home Address: _____, _____ _____
Street *City, Province* *Postal Code*

Employee's Email Address: _____ Telephone No.: ( )_____

Employee's Occupation: _____ Class / Division: _____

Employee's Last Day Worked: _____(dd/mm/yy)

Is this absence due to a work-related injury? ❑ Yes ❑ No *(If Yes, please provide details)*:

Date of Incident/Accident: _____(dd/mm/yy) Place of Accident: _____

Circumstances of Incident: _____

Details of person completing form:

Relationship to Employee/Member (*Please check*): ❑ Employer / Policyholder ❑ Broker ❑ Insured ❑ Other: _____

Name: _____ _____ Date: _____(dd/mm/yy)
(Please Print) *Signature*

Administrator's use only : ****Do not write in this box**** Initials: _____ **Date Reported (to The Wawanesa Life Insurance Company):** _____ (dd/mm/yy)	**The Wawanesa Life Insurance Company Master Policy Number:** _____ **Cert/Div#:** _____ **TPA:** _____ **TPA Contact:** _____ **TPA Email:** _____ **Insured Monthly Benefit:** _____ **Non-Evidence Max:** _____
	If coverage over NEM, was excess medically underwritten: ❑ Yes (please attach form) ❑ No, coverage grandfathered ❑ Not underwritten, 10% rule applied ❑ N/A, under NEM
	The Wawanesa Life Insurance Company LTD Master Policy Effective Date: _____(dd/mm/yy) LTD coverage prior to The Wawanesa Life Insurance Company? ❑ No ❑ Yes Prior Carrier: _____Prior Carrier LTD Effective Date: _____dd/mm/yy)
	Is Life coverage for this group with The Wawanesa Life Insurance Company?: ❑ Yes ❑ No
	Is Unistar currently managing a Short Term claim for this absence? ❑ Yes ❑ No
Have any changes been made to the Insured Person's coverage since the date of loss? ❑ Yes ❑ No (if yes, please provide details) _____	
Are the premiums for this group paid up to date? ❑ Yes ❑ No If no, provide the date paid to: _____(dd/mm/yy)	
Copy of documents required to submit to The Wawanesa Life Insurance Company Claims Department: • Employer Certificate • Employee Enrolment Form • Subsequent-Change of Beneficiary Forms	