

# Notice of Claim – A D & D Coverage



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

This form can be completed in ink (please print) and then returned to **AXA Assurances Inc.** at any of the following addresses:  
Exchange Tower 130 King Street West 23rd floor, Suite 2350, PO BOX 160, Toronto Ontario, M5X 1C7 Fax: (416) 928-0998  
2020 University Street, Suite 700 Montréal, Québec H3A 2A5 Fax: (514) 842-3189  
220 - 12th Avenue S.W., suite 600 Calgary (Alberta) T2R 0E9 Fax: (403) 261-3101

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

Policy Number \_\_\_\_\_ Date notice reported to AXA Assurances Inc. 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 \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_

**Injured/Deceased Insured** \_\_\_\_\_ Date of Birth D M Y \_\_\_\_\_

Relationship to Employee/Member \_\_\_\_\_

Home Address (if different from Employee/Member) \_\_\_\_\_

Date of Accident D M Y \_\_\_\_\_ Place of Accident \_\_\_\_\_

Date of Loss/Death D M Y \_\_\_\_\_

Nature of Loss (Life, Paralysis, Loss of Use of One Arm, etc.) \_\_\_\_\_

Circumstances of Accident \_\_\_\_\_

Amount of Principal Sum \$ \_\_\_\_\_ 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 \_\_\_\_\_