beneva

INVOLUNTARY LOSS OF EMPLOYMENT
INSURED'S STATEMENT

Insured's last name _____ Insured's first name _____

Date of birth: Year Month Day Sex: ☐ F ☐ M

Contract No. _____ Client No. _____

1 Insured's occupation: _____

2 Name and telephone number of employer: _____ Area code Telephone No.

3 Employed by this employer since: Year Month Day

4 Last day worked: Year Month Day

5 When was the insured informed of the loss of employment? Year Month Day

6 Number of hours per week worked for this employer: _____

7 Was the employment:

Temporary? ☐ Yes ☐ No
Contract work? ☐ Yes ☐ No
Part-time? ☐ Yes ☐ No
Seasonal? ☐ Yes ☐ No
Permanent? ☐ Yes ☐ No

8 Was the position held within the insured's own business? ☐ Yes ☐ No

9 Was the insured on strike at the time employment was lost? ☐ Yes ☐ No

10 Was the insured previously absent from work for more than 14 consecutive days due to an illness or an accident? ☐ Yes ☐ No

If so, from Year Month Day to Year Month Day

11 Names and addresses of employers previous to this employment:

Name and address of employer	Start of employment	End of employment
	Year Month Day	Year Month Day
	Year Month Day	Year Month Day
	Year Month Day	Year Month Day

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IND230E (2024-11)

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12 Additional information: _____

_____

_____

_____

INSURED'S STATEMENT

I acknowledge and agree that the answers given in this form are true and complete.

Signed at _____ on _____ this day of _____ 20 _____ .

X _____

Signature of insured

_____ _____

Address (No., street, apt., city, province) Code postal

_____

Area code Home tel.

Protection of personal information

Protecting your personal information is a priority for Beneva. To find out more about our practices, please consult the Personal Information Protection Statement located at beneva.ca.