



AUTOMOTIVE RETAILERS ASSOCIATION



NOTICE OF CLAIM GROUP LONG TERM DISABILITY BENEFITS

(To be completed by employer when there is reason to believe
the member will qualify for Long Term Disability Benefits)

Contract #:	Acct Code #:	Class:	Member Identification #:
Member's Name: (surname first)			Sex:
Birthdate: (month/ day/ year)	Basic Monthly Salary:	Occupation:	
Member's Address: (number and street)		(apt. #.)	
Town/City	Province	Postal Code	
Effective date of Member's coverage: Present status of insurance: <input type="checkbox"/> in force <input type="checkbox"/> cancelled If cancelled, date of cancellation:		Cause of disability:	
Date on which member last worked:			
Remarks			
Employer:		Phone #:	
		Fax #:	
Authorized Signature		Date:	

Please mail or fax this form to:

**Automotive Retailers Association
Unit 1 – 8980 Fraserwood Court
Burnaby, B.C. V5J 5H7**

Fax: (604) 419-0299

For inquiries or assistance, phone the ARA Group Team at: (604) 432-7987