

Death Claim – Combined Statements
CLAIMS DEPARTMENT

MONTRÉAL
P.O. BOX 4002 POSTAL STATION B
MONTRÉAL, QUÉBEC H3B 4M2

I Policyholder statement												
Policyholder name				Policy no.		Division no.		Certificate no.				
Policyholder address (no., street)				City			Province		Postal Code			
Participant surname			Given name			Class no.		Social Insurance No.				
Main residence address (no., street)			Apt.	City		Province	Postal code		Date of birth (YYYY/MM/DD)			
1. Occupation				2. Certificate		Effective (YYYY/MM/DD)		Terminated (YYYY/MM/DD)				
3. Life volume coverage				4. Absences during the last twelve months worked								
Basic				From (YYYY/MM/DD)		To						
Optional				From (YYYY/MM/DD)		To						
Dependent				From (YYYY/MM/DD)		To						
Other				From (YYYY/MM/DD)		To						
5. Nature of request						6. Surname and given name(s) of the deceased						
<input type="checkbox"/> Death of the participant <input type="checkbox"/> Death of a dependent <input type="checkbox"/> Death of a retiree												
<i>If death of participant, please answer questions 7-10</i>												
7. First day worked				8. Last day worked								
<input type="checkbox"/> Full time <input type="checkbox"/> Part time				<input type="checkbox"/> Full time <input type="checkbox"/> Part time								
9. Basic salary paid until				10. Basic salary on the last day of work								
				\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually								
<i>If death of a dependent, please answer question 11</i>												
11. Was the participant actively at work on the date of the dependent's death?												
<input type="checkbox"/> Yes <input type="checkbox"/> No If no, indicate why:												
<i>We hereby certify that the information given above is accurate.</i>												
Authorized employer signee			Telephone no.		Date (YYYY/MM/DD)		Name (please print)					
			()		/ /							
II Claimant statement (each claimant must complete and sign a Claimant statement unless he/she is a minor)												
Name of deceased						Date of birth (YYYY/MM/DD)		Date of death (YYYY/MM/DD)				
Cause of death			If caused by an accident, specify the circumstances									
Claimant (surname and given name)			Social Insurance No.			Date of birth		Marital status				
						(YYYY/MM/DD)		Single	Married	Widowed	Divorced	Other
						/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dated at _____ this _____ day of _____ 20__ I claim in the capacity of <input type="checkbox"/> beneficiary <input type="checkbox"/> legatee <input type="checkbox"/> executor <input type="checkbox"/> heir <input type="checkbox"/> other												
<i>I authorize all physicians and other persons who have treated the deceased and all hospitals, institutions and government authorities to provide to the Standard Life Assurance Company of Canada all information in their possession or within their knowledge with respect to the deceased and to honour a photocopy of this authorization.</i>												
Signature of claimant					Signature of witness							
Complete address					Complete address							
Postal code			Telephone no.		Postal code			Telephone no.				
()			()		()			()				
Dated at _____ this _____ day of _____ 20__					Dated at _____ this _____ day of _____ 20__							
<i>In providing this or other claims forms for the convenience of the Claimant, the Company does not admit any liability or waive any of its rights.</i>												

III Physician statement

This medical certificate is in conformity with the July 24, 1948, recommendations of the World Health Organization in Geneva. It was adopted by all states in the United States and all provinces in Canada.

In order to ensure that vital statistics are accurate, please refer to the International Listing of Causes of Death.

Surname and given name(s) of deceased	Age at death or date of birth (YYYY/MM/DD) / /
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Address at time of death

Place of death (if deceased in a hospital or institution, please give name)	Date of death (YYYY/MM/DD) / /
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Cause of death (state only one cause under each paragraph a, b & c) Illness or morbidity directly related to cause of death. This does not relate to the mode of death, for example, heart failure, etc., but to the illness, lesion or complication which caused death.	Interval between onset of illness and death
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(a) Pre-existent causes. Morbid conditions having eventually caused the above condition. Initial morbid condition to be mentioned last.	(a)
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(b) Caused by or resulting from	(b)
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(c) Caused by or resulting from	(c)
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Other important morbid conditions related to the death, but not related to the illness or the morbid condition, which caused the person to die.

Date on which first treatment was administered for last illness (YYYY/MM/DD) / /	Date on which last treatment was administered for last illness (YYYY/MM/DD) / /
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Specify whether death was due to an accident, suicide or homicide and give a short description of the circumstances.

Was there an inquest? Yes No Was there an autopsy? Yes No

If "Yes", who conducted the inquest or performed the autopsy and what were the findings?

Have you treated the deceased or has he or she consulted you over the three years prior to the last illness? Yes No

To your knowledge, over the last three years, has the deceased been treated by other physicians or in a hospital or other institution? Yes No

If you have answered "Yes" to one of these questions, please provide the following information:

Name	Address	Nature of illness or lesion	Dates (YYYY/MM/DD)
			/ /
			/ /
			/ /

Physician signature	Date (YYYY/MM/DD) / /
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Address
