

DEATH – CLAIM

We cannot settle this claim unless all questions are answered adequately.

Please fill out sections A, B and C and provide the following documents:

FOR AN INSURED

- Birth certificate
- Marriage contract or certificate or act of civil union
- Divorce judgment along with the corollary relief, if applicable
- Will
- Death certificate or burial certificate (ORIGINAL)
- Physician's statement (section D of present form)*
- Notarial copy of letters probate*
- Notarial copy of letters of administration*

FOR A DEPENDENT (spouse - children)

- Dependent's birth certificate
- Marriage contract or certificate or act of civil union
- Certificate of school attendance (03097E)*, if aged from 18 to 25 inclusively or from 21 to 25 inclusively, depending on the contract
- Death certificate or burial certificate (ORIGINAL)
- Physician's statement (section D of present form)*
- Declaration of status for the deceased common-law spouse (01311E)*
- Coroner's report*

ACCIDENTAL DEATH CLAIM

- Police report* Newspaper clipping* Coroner's report*

If the survivor's annuity applies, also submit:

- Spouse and dependent children's birth certificate and social insurance number
- Certificate of school attendance for children aged 18 to 25 inclusively
- Notice of acceptance for surviving spouse's pension from the Régie des rentes du Québec
- Acts of guardianship (for minor orphans)

* These documents are not required in all cases. Please check with the insurer, using the following phone numbers, as well as for any other information you may need:

Toronto area: (416) 926-2990
or toll-free number: 1 800 263-1810

A - EMPLOYER'S STATEMENT

Name of employer				Contract/group number	
Address - No., street				Account/division number	
City		Province		Identification No. of insured	
Postal code		Telephone No.: ()		Ext.	
1. Date of hiring Y M D	2. Coverage effective date Y M D	3. Does the employee work on a part-time basis (more than 25 % and less than 75 % of time)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify the % compared to full-time work %	4. Does the employee work on a full-time basis (more than 75 % of time)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Was the insured disabled before the event? <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Date of beginning of disability Y M D	7. Last date worked Y M D	8. Salary at beginning of disability	9. Annual salary at the date of the event	
10. Return the payment to employer: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Remarks					
DECLARATION - I certify that the information given is complete and true.					
Signature of employer's representative		Title		Date	

B - GENERAL INFORMATION CONCERNING THE DECEASED

Last name of deceased		First name		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth Y M D
Address - No., street		City		Province	Postal code
Was the deceased : <input type="checkbox"/> the insured <input type="checkbox"/> the spouse <input type="checkbox"/> a dependant child					
Occupation		Civil status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil union <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Separated with convention or/and judgment on: Y M D <input type="checkbox"/> Divorced on: Y M D			
1. Date of death Y M D		2. Immediate cause of death - please specify the illness			
3. Name and address of all physicians who treated the deceased during the last two years					
4. Was the death a direct result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date of accident Y M D		5. Type of accident or summary of the circumstances surrounding the accident	
6. Was it a suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No		7. Has there been a coroner's inquest into the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		8. Is the deceased's spouse alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Did the deceased have: <input type="checkbox"/> Yes <input type="checkbox"/> No		a marriage contract? <input type="checkbox"/> Yes <input type="checkbox"/> No		an act of civil union? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		a will? <input type="checkbox"/> Yes <input type="checkbox"/> No		dependent children? <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. (a) Did the deceased ever use tobacco under any form? <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) When did the deceased start smoking? Y M D		(c) When did the deceased stop smoking? Y M D	
(d) Specify non-smoking periods					
12. Did the deceased hold other life insurance contracts with Desjardins Financial Security Life Assurance Company or with a Desjardins caisse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please furnish the following:					
Name of institution		Account number if Desjardins caisse		Name of product	
				Contract/policy number	
				Identification/certificate number	

C - DECLARATION OF RIGHTFUL CLAIMANT (BENEFICIARY)

First name of rightful claimant (beneficiary)	First name	Date of birth	Social insurance number
		Y M D	
Address - No., street			Telephone numbers
City			Home: ()
Province		Postal code	Work: ()
In what capacity are you submitting this claim? <input type="checkbox"/> Spouse <input type="checkbox"/> Beneficiary <input type="checkbox"/> Liquidator of the succession/Testamentary executor <input type="checkbox"/> Other - specify:			Relationship
DIRECT DEPOSIT - If you want your benefits to be deposited directly into your account, please provide us with the information beside and enclose a personalized void cheque.		Identification No. (Transit)	Account number
DECLARATION - I certify that the information given is complete and true.			
Signature of rightful claimant (beneficiary)			Date
AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION			
I authorize Desjardins Financial Security Life Assurance Company, strictly for the purposes of determining the deceased's insurability, managing his/her file and settling his/her claims to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary for processing the deceased's file. The non-exhaustive list of sources from which information may be collected includes health care professionals or facilities, the Medical Information Bureau, insurance companies, personal information officers or investigation agencies, the policyholder, his/her employer or former employers; (b) communicate to the said persons or organizations only the personal information about the deceased that is deemed necessary for the purposes of his/her file; (c) when necessary, request an inquiry report about the deceased, and also use the personal information it may have about him/her in existing files that are now closed. A photocopy of this authorization is as valid as the original.			
Signature of rightful claimant (beneficiary)			Date

D - PHYSICIAN'S STATEMENT – The rightful claimant (beneficiary) is responsible for any fee requested to complete this declaration.

Last name of deceased	First name	Date of death	Place of death
		Y M D	
Residence at death - No., street		City	Province Postal code
If the deceased died in a hospital or in another institution, give the name:			
Age at death:	OR	Date of birth:	Y M D
1. Disease or condition directly leading to death (This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complication which caused death):			Interval between onset and death
2. Antecedent causes (morbid conditions, if any, giving rise to the above condition) due to or as a consequence of:			
(a)			
(b)			
3. (a) Other significant conditions (contributing to the death but not related to the disease or condition causing death):			
(b) Was death related to acquired immunodeficiency syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Date of first attendance in last illness	5. Date of last attendance in last illness	6. Date of diagnosis	7. When was the deceased informed the first time about this illness?
Y M D	Y M D	Y M D	Y M D
8. Was the death due to: <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide Describe briefly:			
9. Was an inquest held? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by whom and with what findings:			
10. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by whom and with what findings:			
11. Have you treated or advised the deceased during the last 3 years, prior to last illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please furnish the following:			
Nature of illness or injury	Hospital or institution	Address	Date
_____	_____	_____	_____
_____	_____	_____	_____
12. Did the deceased, to your knowledge, receive treatment during the last 3 years of his life from any other physician, or in any hospital or institution? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please furnish the following:			
Nature of illness or injury	Physician, hospital or institution	Address	Date
_____	_____	_____	_____
_____	_____	_____	_____
13. Did the deceased ever use tobacco under any form? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. When did the deceased start smoking?		15. When did the deceased stop smoking?
	Y M D	Y M D	
16. Specify non-smoking periods:			
Name and address of physician (PLEASE PRINT)		Signature of physician	
		Date	License No.
		Specialty	
Postal code		Telephone	Fax
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