CLAIMANT STATEMENT DEATH CLAIM (SIMPLIFIED VERSION)

- *LIFE INSURANCE ISSUED MORE THAN 10 YEARS AGO AND VALUED AT LESS THAN $200,000*
- *INVESTMENT-RETIREMENT*

1. Name of the deceased: ______________________________ SIN: _____/_____/______

   Address ______________________________ Date of birth: _____/______/_____

   Marital status at time of death: ❑ Single ❑ Married ❑ Widow ❑ Divorced since ________________

   ❑ common law spouse ❑ Separated since ____________ ❑ Legally separated since ____________

2. Claim Request: Policy: ______________ Sum Insured (if known) ________________

   ______________ ________________

   ❑ contract enclosed ❑ contract not found

3. Death: Date: ______/______/______ Where: ______________________________

   a) Immediate cause of death: ______________________________

   b) When did illness start? ______________________________

4. Use of tobacco

   Was the deceased smoking, using tobacco, tobacco cessation products or marijuana? ❑ Yes ❑ No

   If YES, since when? ________________ Indicate daily consumption ________________

   If NO, has he(she) already smoked or made use of tobacco, tobacco cessation products or marijuana? ❑ Yes ❑ No If YES, when did he(she) stopped? ____________ Indicate daily consumption before stopping? ____________

5. Name of Claimant: ________________ Are you beneficiary, heir, other? ____________

   Name of Beneficiary: ________________ Date of Birth: ______/______/______ SIN: _____/_____/____

The claim will be paid to the designated beneficiary according to the documents received by the Company to date. Please advise us of the existence of any other document indicating any other beneficiary designation and send it to us as soon as possible.

I certify in good faith that the answers above are true and complete and that they are provided in order to obtain the insurance benefits described above. I hereby authorize and request from any physician who would have given care or medically examined the deceased person and from any hospital, civil servant, CPP or RRQ, to provide UL Mutual or its reinsurers all the information they have or of which they are aware concerning the health status of the deceased person. **A photocopy of this authorization will be as valid as the original.**

Claimant Signature: ______________________________ Date: _________/________/________

Address: ______________________________ Tel.: (______) ________- __________

Witness Signature: ______________________________ Date: ________/________/_________

❑ I wish to have the claim payment be:

❑ mailed directly to the beneficiary or to the power of attorney
❑ delivered by my insurance advisor
❑ invested at UL Mutual (send a completed application)

❑ I am electing that the spousal rollover be applied (for Investment-Retirement only)

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