



CLAIMANTS STATEMENT DEATH CLAIM

LIFE INSURANCE ISSUED LESS THAN 10 YEARS AGO OR FOR A VALUE OF OVER \$200,000

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? _____
 c) Date of first consultation for this illness? _____

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. Physicians consulted during the last two (2) years:
 Name: _____ Name: _____
 Address: _____ Address: _____
 Date: _____ Date: _____
 Family doctor's name: _____
 Address: _____

6. Other life insurance policies for the deceased:

	Company	Policy Issuance Date	Sum Insured
a)	_____	_____	_____
b)	_____	_____	_____

7. 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)