Life Insurance Claim – Beneficiary's (Claimant) Statement

______________________ First Name of the deceased
______________________ Last Name of the deceased
__________ Policy Number

Section 1 – Beneficiary's (Claimant's) Information

In what capacity are you making this claim?

☐ Beneficiary ☐ Executor/Liquidator ☐ Trustee ☐ Assignee ☐ Other (specify): ______________________

The Social Insurance Number or Business Number is required for reporting of interest and/or other tax reporting requirements.

If you are a beneficiary making this claim, please provide your Social Insurance Number (SIN)______________________

If you are a representative of an estate making this claim, please provide the deceased insured's SIN______________________

If you are a representative of a corporate beneficiary, please provide the Business Number used for tax purposes______________________

If you are a trustee making this claim on behalf of a beneficiary, please provide the beneficiary's SIN______________________

Your business is located in Quebec, please also provide the Quebec Business Number______________________

______________________ First Name of the beneficiary
______________________ Last Name of the beneficiary
__________ Date of Birth (DD/MM/YYYY)

______________________ Address of the beneficiary
______________________ City/Town
__________ Province
__________ Postal Code

______________________ Telephone - Home
______________________ Telephone – Work
______________________ Telephone – Cell Phone

______________________ Relationship to insured

Gender: ☐ F ☐ M

______________________ Claimant's Name (if different from the beneficiary's)
______________________ Claimant's Telephone

______________________ Claimant's Complete Address
______________________ Claimant's e-mail address

Section 2 – Deceased's Information

1. Name of deceased : ______________________
   Date of birth : (DD/MM/YYYY) ______________ Date of death : (DD/MM/YYYY) ______________
2. Complete address where person was residing at time of death : ______________________
   ____
3. Name and address of personal physician(s) or family doctor(s) consulted by the insured in the last 5 years preceding death :
   Name :______________________City :______________________From which date : ______________
   Name :______________________City :______________________From which date : ______________
   Did the deceased use any form of tobacco or product containing nicotine? ☐ Yes ☐ No ☐ Unknown
   If yes, specify dates :______________________
4. Cause of death: ______________________
5. Was the death accidental? ☐ Yes ☐ No ☐ Unknown
   (If death was accidental, attach coroner's report. Do not wait for the coroner's report to send other documents.)
6. Date the health of the deceased started to decline : (DD/MM/YYYY) ______________
7. Date first treatments related to cause of death were received : (DD/MM/YYYY) ______________

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-800-455-7337 Fax 1-855-230-2500 email: claims@assumption.ca

8. Place of death : ☐ Home ☐ Hospital ☐ Nursing Home ☐ Other (specify): ______________________________

9. Did death occur in Canada? ☐ Yes ☐ No
   If the death occurred outside of Canada or the U.S.A., Form 4765-00A Foreign Death Questionnaire must also be completed.

10. Did the deceased consult any physician in the past three (3) years? ☐ Yes ☐ No ☐ Unknown
    Was the deceased hospitalized within the past three (3) years? ☐ Yes ☐ No ☐ Unknown

Name and Address of Physician or Hospital	Date/Duration	Reason

Section 3 – Beneficiary's (Claimant's) Authorization & Acknowledgement

Choose one of the following options (if no choice is made, the cheque will be sent to the advisor):
☐ Direct Deposit (see attached form named *Direct Deposit Authorization*) ☐ Mail cheque to address indicated in Section 1
☐ Send cheque to the Assumption Life advisor ☐ Invested in Assumption Life's diversified products*
***A financial advisor will contact you shortly to guide you towards the solution that will best meet your needs.**

Declaration of tax residence for the beneficiary (claimant)
Please indicate all of the options that apply to you in respect to Section 1 of this form.
☐ **I am a tax resident of Canada.** If you ticked this box, give your social insurance number. Social insurance number ___________________
☐ **I am a tax resident or a citizen of the United States**.
If you ticked this box, give your taxpayer identification number (TIN) from the United States. TIN from the United States ___________________
If you do not have a TIN from the United States, have you applied for one? ☐ Yes ☐ No
☐ **I am a tax resident of a jurisdiction other than Canada or the United States**.
If you ticked this box, give your jurisdictions of tax residence and taxpayer identification numbers. ___________________
If you do not have a TIN for a specific jurisdiction, give the reason using one of these choices:
Reason 1 : I will apply or have applied for a TIN but have not yet received it.
Reason 2 : My jurisdiction of tax residence does not issue TINs to its residents.
Reason 3 : Other reason.
For this form, "other reason" is enough. However, you still have to tell your financial institution the specific reason.

Jurisdiction of tax residence	Taxpayer identification number	If you do not have a TIN, choose reason 1, 2, or 3.

***For Assignee**, you will be required to complete a *Declaration of Tax Residence for Entities- Part XVIII and Part XIX of the Income Tax Act*. This form will be provided to you upon reception of this claim.

I hereby confirm that the information contained in this claim form is true and complete to the best of my knowledge.

I hereby authorize Assumption Life to access, copy and review any files in its possession relating to the deceased for the purpose of investigating and processing the deceased's life insurance claim. I also authorize the use of the social insurance number with respect to this claim.

I hereby authorize any healthcare provider or professional, medical organization, insurance company, reinsurer, the investigation and credit reporting agencies, worker's compensation board, and any other person and private or public organization or institution to disclose any personal or health information, records or knowledge about the deceased to Assumption Life, its employees, its reinsurers or to any agency acting on behalf of Assumption Life for the purpose of investigating and processing the insurance claim related to the deceased.

I understand and acknowledge that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, Assumption Life will have the right to use and exchange any information related to the claim with any relevant regulatory, investigative or government body, any healthcare provider or professional or medical organization, insurance company or reinsurer, the policyholder, my employer or any other party as provided by law for the purpose of investigating any such fraud or abuse. I agree that a photocopy of this authorization & acknowledgement is as valid as the original.

____ _______________________
Beneficiary's signature (Claimant) Date (DD/MM/YYYY)

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