

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 tobacco or nicotine products, including, but not limited to cigarettes, large cigars (more than 12), cigarillos, marijuana or cannabis mixed with tobacco, e-cigarettes, vaping devices, gum, patches, chewing tobacco, snuff, betel nuts, shisha, or hookah/water pipes?

Yes, since when? _____ Which form? _____

No, date ceased (if used in the past): _____

Never used any form of tobacco or nicotine products, as outlined above

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) _____

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 five (5) years? Yes No Unknown

Was the deceased hospitalized within the past five (5) 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 :

Direct Deposit (please attach a void cheque) 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)