UV INSURANCE

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)

EQC020 (18-11)

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