



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)