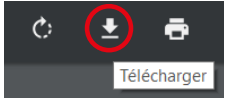
Steps to complete the form

1 Click on the download button for save the form on your computer.



2 Fill in the fields of the form and save your information before submitting it to us.

UV INSURANCE

DEATH CLAIM

GROUP INSURANCE

EMPLOYER'S DECLARATION

NAME OF EMPLOYER	GROUP	DIVISION	CERTIFICATE

DATE HIRED (D M Y)	DATE DECEASED (D M Y)	LAST JOB OCCUPIED	LAST DAY WORKED	FULL TIME (D M Y)	PART TIME (D M Y)

IF EMPLOYEE WAS NOT AT WORK UP UNTIL DATE DECEASED, PLEASE SPECIFY WHY (SICKNESS, VACATION, RETIREMENT)

IS EMPLOYEE'S CERTIFICATE STILL EFFECTIVE?	WORK ACCIDENT RELATED?	INSURANCE AMOUNT	LAST SALARY
☐ YES ☐ NO	☐ YES ☐ NO	$	$ ☐ WORKING HOURS (SPECIFY #) _____ ☐ WEEKLY ☐ MONTHLY ☐ YEARLY

SALARY EFFECTIVE SINCE : (D M Y)	IF THE DECEASED IS A DEPENDANT PERSON, INDICATE THE EFFECTIVE DATE OF DEPENDANT COVERAGE. (DAY MONTH YEAR)

NAME OF EMPLOYER	DATE

PREPARED BY	TITLE

DECLARATION OF ELIGIBLE PARTY

INFORMATION ON DECEASED PERSON

NAME AND SURNAME OF DECEASED PERSON (NAME AT BIRTH)

DATE (D M Y) PLACE OF BIRTH	DATE (D M Y) PLACE OF DEATH	SOCIAL INSURANCE NUMBER

LAST ADDRESS	POSTAL CODE

MARITAL STATUS UPON DEATH	DID THE DECEASED HAVE: (IF YES, PLEASE ATTACH A COPY)	CAUSE OF DEATH
☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SINGLE ☐ SEPARATED ☐ COMMON LAW	1. A MARRIAGE CONTRACT ☐ YES ☐ NO 2. A TESTAMENT ☐ YES ☐ NO	

IF DEATH IS DUE TO AN ACCIDENT, GIVE DETAILS (DATE, PLACE, CIRCUMSTANCES)

PHYSICIANS CONSULTED DURING THE PAST 2 YEARS

NAME	ADDRESS

IF THE DECEASED IS A DEPENDANT PERSON RELATIONSHIP WITH EMPLOYEE	NAME OF SCHOOL ATTENDED, IF CHILD AGED OVER 18 YEARS

OTHER CURRENT INSURANCE POLICIES

NAME OF INSURANCE COMPANY	AMOUNT	ISSUED ON:

INFORMATION ON ELIGIBLE PARTY

NAME AND SURNAME OF ELIGIBLE PARTY	DATE OF BIRTH (D M Y)	RELATIONSHIP WITH DECEASED

SOCIAL INSURANCE NUMBER	MARITAL STATUS UPON DEATH	YOU ARE APPOINTED TO SUBMIT THIS REQUEST FOR SETTLEMENT AS:
	☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SINGLE ☐ SEPARATED ☐ COMMON LAW	☐ BENEFICIARY ☐ CONTRACTING ☐ LEGATEE ☐ EXECUTOR ☐ GUARDIAN

LAST ADDRESS	POSTAL CODE

IF THE PERSON DECEASED IS A COMMON LAW SPOUSE, SINCE WHAT DATE WERE YOU LIVING TOGETHER? DAY _____ MONTH _____ YEAR _____

I CERTIFY THAT THE INFORMATION SUBMITTED IS COMPLETE, TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

DATE	X SIGNATURE OF WITNESS	X SIGNATURE OF ELIGIBLE PARTY

PLEASE SUBMIT WITH THIS REQUEST:

1. BIRTH CERTIFICATE (ORIGINAL)
2. DEATH CERTIFICATE EMITTED BY THE REGISTRY OFFICE

569-A (11-12)

P.S. PHYSICIAN'S STATEMENT MUST BE COMPLETED ON REVERSE SIDE

MEDICAL DEATH CERTIFICATE

NAME AND SURNAME OF DECEASED PERSON	DATE DECEASED

RESIDENCE UPON DEATH	PLACE OF DEATH
AGE UPON DEATH OR BIRTH DATE	IF DECEASED IN A HOSPITAL OR INSTITUTION, GIVE NAME

CAUSE OF DEATH (INDICATE ONE REASON PER PARAGRAPH 1,2A AND 2B).	INTERVAL BETWEEN ETIOLOGICAL BEGINNING AND DEATH
1. SICKNESS OR MORBID STATE, THAT DIRECTLY PROVOKED THE DEATH (NOT THE CIRCUMSTANCES OF THE DEATH EXAMPLE: HEART FAILURE, SYNCOPE, ETC. BUT THE SICKNESS, THE LESION OR THE COMPLICATION WHICH LED TO THE DEATH).	1.
2. PREVIOUS CAUSES (MORBIT STATES WHICH EVENTUALLY LED TO STATE MENTIONED ABOVE, INDICATE INITIAL MORBID STATE LAST).	2.
A. _____ PROVOKED BY OR CONSECUTIVE	A.
B. _____ PROVOKED BY OR CONSECUTIVE	B.
3. OTHER SIGNIFICANT MORBID STATES: (CONTRIBUTED TO THE DEATH BUT NOT RELATED TO THE SICKNESS OR MORBID STATE) _____ _____	3.

DATE OF FIRST TREATMENT FOR LAST SICKNESS DAY _____ MONTH _____ YEAR _____	DATE OF LAST TREATMENT FOR LAST SICKNESS DAY _____ MONTH _____ YEAR _____
SPECIFY IF DEATH IS DUE TO AN ACCIDENT, SUICIDE OR HOMICIDE AND BRIEFLY DESCRIBE. _____ _____ _____ _____	WAS AN INVESTIGATION CONDUCTED? ☐ YES ☐ NO WAS AN AUTOPSY CARRIED OUT? ☐ YES ☐ NO **IF YES, BY WHOM AND GIVE FINDINGS?** _____ _____ _____

DID YOU TREAT THE DECEASED PERSON OR GIVE CONSULTATIONS DURING THE PAST THREE YEARS PRECEDING THE CURRENT SICKNESS? ☐ YES ☐ NO

TO YOUR KNOWLEDGE, DURING THE PAST THREE YEARS, DID THE DECEASED PERSON UNDERGO TREATMENTS BY OTHER PHYSICIANS, HOSPITAL OR INSTITUTION? ☐ YES ☐ NO

IF YOU HAVE ANSWERED YES TO ONE OF THESE QUESTIONS, PLEASE GIVE THE FOLLOWING DETAILS:

NAME (PHYSICIANS, HOSPITAL, INSTITUTION)	ADDRESS	NATURE OF SICKNESS OR LESION	DATES

X		X	
DATE	**NAME OF PHYSICIAN (PRINT)**	**SIGNATURE OF PHYSICIAN**	
ADDRESS			

CITY	PROVINCE	POSTAL CODE

P.S. CHARGES FOR THIS DECLARATION SHALL BE PAID BY THE BENEFICIARY