Desjardins Insurance
LIFE • HEALTH • RETIREMENT

P.O. Box 4593 STN A
Toronto ON M5W 4X7

DEATH – CLAIM
CLAIMANT'S STATEMENT

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We cannot settle this claim unless all questions are answered adequately.

- Please complete sections A, B and C and provide the Claim – Employer's Statement (form no. 12123E01) along with the required documents.
- This form must be filled out by the designated beneficiary or, in the absence of a beneficiary, the executor.
- If the beneficiary is incapacitated or a minor, this form must be filled out by their guardian or representative.
- If there is more than one beneficiary, each must fill out a form.
- Death certificate must be attached to the completed form. Prior to sending one of the following forms, please contact our Customer Contact Centre since other documents may be required.

To contact us: **Toronto area: 416-926-2990** **Toll free number: 1-800-263-1810**

A. Information about the deceased

Last name	First name	Sex ☐M ☐F	Date of birth YYYY-MM-DD	Was the deceased: ☐the insured ☐the spouse ☐a dependent child
Address - No., street	City	Province	Postal code	
Employer of principal insured	Contract/group no.	Account/division no.	Identification no. of the insured	
Occupation	Civil status ☐Single ☐Married ☐Joined in civil union ☐Common-law spouse ☐Widowed ☐Separated - if applicable, with judgement or agreement on YYYY-MM-DD ☐Divorced on YYYY-MM-DD			
1. Date of death YYYY-MM-DD	2. Place of death	3. Cause of death		

4. Name and address of all physicians who treated the deceased during the last two years

5. Was the death a result of an accident? ☐Yes ☐No	If yes, date of accident YYYY-MM-DD	6. Type of accident or summary of the circumstances surrounding the accident

7. Was it a suicide? ☐Yes ☐No	8. Has there been a coroner's inquest into the cause of death? ☐Yes ☐No	9. Is the deceased's spouse alive? ☐Yes ☐No	10. Does the spouse have custody of the children? ☐Yes ☐No

11. Did the deceased have (answer yes or no to each question; if **yes**, give the date of the document):

A will ☐Yes ☐No Date YYYY-MM-DD	A marriage contract ☐Yes ☐No Date YYYY-MM-DD	An act of civil union ☐Yes ☐No Date YYYY-MM-DD
A declaration of heirs ☐Yes ☐No Date YYYY-MM-DD	Dependent children? ☐Yes ☐No If yes, indicate the number of children and their age:	

12. (a) Did the deceased ever use tobacco under any form? ☐Yes ☐No	(b) When did the deceased start smoking? YYYY-MM-DD	(c) When did the deceased stop smoking? YYYY-MM-DD	(d) Specify non-smoking periods

13. Did the deceased hold other life insurance contracts with Desjardins Financial Security Life Assurance Company or with a Desjardins caisse? ☐Yes ☐No If yes, please furnish the following:

Name of institution	Account number if Desjardins caisse	Name of product	Contract/policy number	Identification/certificate number

B. Identification of claimant

Last name	First name	Date of birth YYYY-MM-DD	Social insurance no.
Address - No., street			Telephone nos. Home: AREA CODE + NUMBER
City	Province	Postal code	Work: AREA CODE + NUMBER

In what capacity are you requesting payment of the death benefit? ☐Contract-designated beneficiary ☐Liquidator of the succession ☐Spouse ☐Guardian ☐Other, specify:

DIRECT DEPOSIT - If you want your benefits to be deposited directly into your account, complete this section and enclose a void cheque.	Identification no. (Transit)	Account no.

DECLARATION – I declare that the information provided above is complete and true.

Signature of claimant _____ **Date** _____

C. Authorization to collect and communicate personal information

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Financial Security Life Assurance Company (DFS) or its reinsurers: a) to collect from any individual, legal entity or public or parapublic organization only the personal information they have about the deceased that is needed to process the file. This information may be collected from third parties, including any health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, his/her employer or his/her former employers; b) to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about the deceased that is needed to manage the file. Such information may include the deceased's will, death certificate, will search certificate, or beneficiary designation, if applicable; c) to request, if applicable, an investigation report about the deceased and to use the personal information contained in other files it may have that are now closed; d) to disclose to other insurers or reinsurers any information about the deceased that is relevant to determining his/her eligibility for insurance or for benefits. This authorization also applies to the collection, use and communication of personal information regarding the deceased's dependents, insofar as applicable to his/her claim. A photocopy of this authorization is as valid as the original.

Signature of the beneficiary or the executor (-trix) _____ **Date** _____