CHUBB®

PROOF OF ACCIDENTAL DEATH
CLAIMANT'S STATEMENTS

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

ATTACH CERTIFIED COPY OF DEATH CERTIFICATE
PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

Policy No.			
1.	**Full name of Deceased:**		
2.	**Full address of the Deceased at death:** **Street Address:**		
	City:	**Province:**	**Postal Code:**
3.	**Date of birth of Deceased:**		
4.	**Please, date and time of death:**		
5.	**(a) Occupation fo Deceased at death:**		
	(b) Name and address of Employer: **Street Address:**		
	City:	**Province:**	**Postal Code:**
6.	**(a) On what date did the accident occur?**	**(b) Approximate time of accident:**	
	(c) Specifically, where did the accident occur?		
7.	**How did the accident occur? (answer fully)**		
8.	**Who was present at the time of the accident? (Witness) Please list names and addresses.**		
9.	**What injury or injuries were sustained?**		
10.	**Was an Autopsy or Inquest held? ☐ Yes ☐ No**		
	If yes, give the name of the agency called and attach a copy of the report if available to you.		
11.	**Were the police called to the scene of the accident? ☐ Yes ☐ No**		
	If yes, give the name of the agency called and attach a copy of the report if available.		
12.	**(a) State name and address of the doctor or Hospital that first attended after the injury.**		
	(b) Also, name and address of the doctor or hospital that attended the Deceased at the time of death.		

13. Did the Deceased have a family doctor? ☐ Yes ☐ No If yes, give the doctor's name and address.	
14. Did the Deceased see a doctor for an injury or sickness in the last two years? ☐ Yes ☐ No If yes, when and what for?	
Give the doctor's name and address.	
15. Did the Deceased carry any other Accident or Life Insurance?	
If so, state the name of the Insurer:	
Address:	
Policy Numbers:	
Amounts Carried:	
(a) What is your full name?	**(b) Date of birth:**
(c) Relation to the Deceased?	
16. Your Social Insurance # (required for tax purposes):	
17. Remarks	

Claimant's Certification: The above statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered without refund of any premiums paid. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

Privacy Notice: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Chubb Insurance and/or Chubb Life Insurance, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. The Insurer will establish a claims file to which access will be restricted to authorized employees and agents of the Insurer and to persons authorized by law. If I have the right to access the information, access will be given to me or such persons as I may authorize. I understand that in some instances, the employees, service providers, agents, reinsurers, and any of their providers, of Chubb may be located in jurisdictions outside Canada and my personal information may be subject to the laws of those foreign jurisdictions. I consent to the collection, use, and distribution of my personal information as may be required for these purposes as of the date of signing of this Claimant Statement and understand that such consent will remain in place until such time as I may revoke it.

To find out more about the Chubb Privacy Policy or our privacy practices please visit chubb.com/ca or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.

Authorization: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Chubb Insurance/Chubb Life Insurance, or representatives thereof, all personal health information, benefit payment or financial information about the insured or any other information or records about the insured in its possession that is requested while administering this claim.

I agree that a photocopy of this authorization shall be as valid as the original.

Full Mailing Address of Claimant:		
Address:		
City:	**Province:**	**Postal Code:**
Phone # of Claimant ( )		

Signature of Claimant _____ Date _____