Desjardins Financial Security®

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

Print | Reset | LIFE CLAIMS

DEATH – CLAIM

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

Please fill out sections A, B and C and provide the following documents:

FOR AN INSURED	FOR A DEPENDENT (spouse - children)
☐ Birth certificate	☐ Dependent's birth certificate
☐ Marriage contract or certificate or act of civil union	☐ Marriage contract or certificate or act of civil union
☐ Divorce judgment along with the corollary relief, if applicable	☐ Certificate of school attendance (03097E01)*, if aged from 18 to 25 inclusively or from 21 to 25 inclusively, depending on the contract
☐ Will	☐ Death certificate or burial certificate (ORIGINAL)
☐ Death certificate or burial certificate (ORIGINAL)	☐ Physician's statement (section D of present form)*
☐ Physician's statement (section D of present form)*	☐ Declaration of status for the deceased common-law spouse (01311E01)*
☐ Notarial copy of letters probate*	☐ Coroner's report*
☐ Notarial copy of letters of administration*	

ACCIDENTAL DEATH CLAIM

☐ Police report* ☐ Newspaper clipping* ☐ Coroner's report*

If the survivor's annuity applies, also submit:

- ☐ Spouse and dependent children's birth certificate and social insurance number
- ☐ Certificate of school attendance for children aged 18 to 25 inclusively
- ☐ Notice of acceptance for surviving spouse's pension from the Régie des rentes du Québec
- ☐ Acts of guardianship (for minor orphans)

* **These documents are not required in all cases. Please check with the insurer, using the following phone numbers, as well as for any other information you may need:** **Toronto area: 416-926-2990** **or toll-free number: 1-800-263-1810**

A - EMPLOYER'S STATEMENT

Name of employer

Contract/group number

Address - No., street

Account/division number

City Province

Identification number of the insured

Postal code Telephone No.: Area code + number Ext.

1. Date of hiring YYYY-MM-DD
2. Coverage effective date YYYY-MM-DD
3. Does the employee work on a part-time basis (more than 25% and less than 75% of time)? ☐ Yes ☐ No — If yes, specify the % compared to full-time work %
4. Does the employee work on a full-time basis (more than 75% of time)? ☐ Yes ☐ No
5. Was the insured disabled before the event? ☐ Yes ☐ No
6. Date of onset of disability YYYY-MM-DD
7. Last date worked YYYY-MM-DD
8. Salary at onset of disability
9. Annual salary at the date of the event
10. Return the payment to employer: ☐ Yes ☐ No

Remarks

DECLARATION - I certify that the information given is complete and true.

Signature of employer's representative **Title** **Date**

B - GENERAL INFORMATION CONCERNING THE DECEASED

Last name of deceased First name Sex ☐ M ☐ F Date of birth YYYY-MM-DD

Address - No., street City Province Postal code

Was the deceased: ☐ the insured ☐ the spouse ☐ a dependent child

Occupation

Civil status ☐ Single ☐ Married ☐ Civil union ☐ Widowed ☐ Separated ☐ Separated with convention or/and judgment on: YYYY-MM-DD ☐ Divorced on: YYYY-MM-DD

1. Date of death YYYY-MM-DD
2. **Immediate cause of death - please specify the illness**
3. Name and address of all physicians who treated the deceased during the last two years
4. Was the death a direct result of an accident? ☐ Yes ☐ No — If yes, date of accident YYYY-MM-DD
5. Type of accident or summary of the circumstances surrounding the accident
6. Was it a suicide? ☐ Yes ☐ No
7. Has there been a coroner's inquest into the cause of death? ☐ Yes ☐ No
8. Is the deceased's spouse alive? ☐ Yes ☐ No
9. Does the spouse have custody of the children? ☐ Yes ☐ No
10. Did the deceased have: a marriage contract? ☐ Yes ☐ No — an act of civil union? ☐ Yes ☐ No — a will? ☐ Yes ☐ No — dependent children? ☐ Yes ☐ No — If yes, indicate the number of children and their age
11. (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
12. 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

100%

C - DECLARATION OF THE BENEFICIARY OR THE EXECUTOR (-TRIX)

Last name of the beneficiary or the executor (-trix)	First name	Date of birth YYYY-MM-DD	Social insurance no.

Address - No., street

City | Province | Postal code

Telephone nos.
Home: Area code + number
Work: Area code + number

In what capacity are you submitting this claim? ☐ Spouse ☐ Beneficiary ☐ Liquidator of the succession/Testamentary executor ☐ Other - specify:

Relationship

DIRECT DEPOSIT - If you want your benefits to be deposited directly into your account, please provide us with the information beside and enclose a personalized void cheque.

Identification No. (Transit) | Account number

DECLARATION - I certify that the information given is complete and true.

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

AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

I authorize Desjardins Financial Security Life Assurance Company, strictly for the purposes of determining the deceased's insurability, managing his/her file and settling his/her claims to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary for processing the deceased's file. The non-exhaustive list of sources from which information may be collected includes health care professionals or facilities, the MIB (formerly known as Medical Information Bureau), insurance companies, personal information officers or investigation agencies, the policyholder, his/her employer or former employers; (b) communicate to the said persons or organizations only the personal information about the deceased that is deemed necessary for the purposes of his/her file; (c) when necessary, request an inquiry report about the deceased, and also use the personal information it may have about him/her in existing files that are now closed. A photocopy of this authorization is as valid as the original.

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

PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security Life Assurance Company (DFS) handles the personal information it has on you in a confidential manner. DFS keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by DFS employees who need to do so in the course of their work. You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Financial Security Life Assurance Company, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. DFS may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at DFS.

D - PHYSICIAN'S STATEMENT – The beneficiary or the executor (-trix) is responsible for any fee requested to complete this declaration.

Last name of deceased	First name	Date of death YYYY-MM-DD	Place of death

Residence at death - No., street | City | Province | Postal code

If the deceased died in a hospital or in another institution, give the name:

Age at death: OR Date of birth: YYYY-MM-DD

1. Disease or condition directly leading to death (This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complication which caused death): | Interval between onset and death

2. Antecedent causes (morbid conditions, if any, giving rise to the above condition) due to or as a consequence of:
   (a)
   (b)

3. (a) Other significant conditions (contributing to the death but not related to the disease or condition causing death):

(b) Was death related to acquired immunodeficiency syndrome? ☐ Yes ☐ No

4. Date of first attendance in last illness	5. Date of last attendance in last illness	6. Date of diagnosis	7. When was the deceased informed the first time about this illness?
YYYY-MM-DD	YYYY-MM-DD	YYYY-MM-DD	YYYY-MM-DD

8. Was the death due to: ☐ accident ☐ suicide ☐ homicide Describe briefly:

9. Was an inquest held? ☐ Yes ☐ No If yes, by whom and with what findings:

10. Was an autopsy performed? ☐ Yes ☐ No If yes, by whom and with what findings:

11. Have you treated or advised the deceased during the last 3 years, prior to last illness? ☐ Yes ☐ No
    If yes, please furnish the following:

Nature of illness or injury	Hospital or institution	Address	Date

12. Did the deceased, to your knowledge, receive treatment during the last 3 years of his life from any other physician, or in any hospital or institution? ☐ Yes ☐ No If yes, please furnish the following:

Nature of illness or injury	Physician, hospital or institution	Address	Date

13. Did the deceased ever use tobacco under any form? ☐ Yes ☐ No	14. When did the deceased start smoking? YYYY-MM-DD	15. When did the deceased stop smoking? YYYY-MM-DD

16. Specify non-smoking periods:

Name and address of physician (PLEASE PRINT)	**Signature of physician**	
	Date	License No.
	Specialty	
Postal code	Telephone Area code + number	Fax Area code + number