



## Claimant's Statement Regarding Death Group Policy # 901102

Claim No. \_\_\_\_\_  
(Manulife Office use only)

1. Type of Claim (Please check appropriate box)	2. Deceased (Please check appropriate box)
<input type="checkbox"/> Optional Group Term Insurance (OGTI) <input type="checkbox"/> Reserve Term Insurance Plan (RTIP) <input type="checkbox"/> Dependant Life Insurance (DL) <input type="checkbox"/> General Officer's Insurance Plan (GOIP) <input type="checkbox"/> Post Retirement Continuation Plan (PRCP) <input type="checkbox"/> Military Post Retirement Life Insurance Plan (MPRLIP) <input type="checkbox"/> Coverage After Release (CAR) <input type="checkbox"/> Insurance for Released Members (IRM) <input type="checkbox"/> Paid Up Certificate	<input type="checkbox"/> Serving Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child/Dependant <input type="checkbox"/> Former Member <input type="checkbox"/> Ex-Spouse

3. Certificate Holder's Information		
Service Number (SN):	Surname:	First Name:
Address: _____		
Email Address: _____		
Home Phone #:	Work Phone #: (if applicable)	
Was or is your spouse a serving member of the Canadian Forces?		
If so, spouse's name _____ Service Number (SN) _____		

4. Deceased's Information		
Surname:	First Name:	Date of Birth: _____ <small style="text-align: center;">Day      Month      Year</small>
Address at time of death: <input type="checkbox"/> Same as certificate holder or:		
Place of Death	Date of Death: _____ <small style="text-align: center;">Day      Month      Year</small>	
Cause of Death (If stillborn, indicate weight & # of weeks into pregnancy)		
If the cause of death is illness:		
A) When did deceased first complain or give indications of illness?		
B) When did deceased first consult a physician for illness?		

Service Number (SN)
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Claimant's Statement Regarding Death continued...

**5. Deceased's Physician Information**

Names and addresses of all physician's, other than military medical officers, who attended the deceased during the last three years.

Names	Addresses
_____	_____
_____	_____
_____	_____

**6. Complete for Dependant Life claims only.**

Was the dependant . . . .

Student?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Full time	<input type="checkbox"/> Part time
Married?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Dependant on you for financial support?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Employed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Full time	<input type="checkbox"/> Part time

**7. Claimant's Information**

Surname:		First Name:	
S.I.N.	Home Phone #:	Work Phone #:	
Address:			
Relationship to the deceased person:		Amount Claimed: \$	
Date of birth: _____			
Day	Month	Year	

**8. Claimant's Signature**

**Declaration and Authorization by Claimant**

- a. I certify that all information given on this form is complete and true in every respect;
- b. I understand that the completion of this form is not an admission of any liability on the part of SISIP Financial Services or Manulife Financial ;
- c. I authorize SISIP Financial Services, Manulife Financial or its reinsurers, for underwriting, administration of insurance and claims paying purposes, to gather only the necessary information for the object of the file, from any physician, hospital, pension board or any person or organization that has personal information relating to the deceased;
- d. I also authorize SISIP Financial Services and Manulife Financial or its reinsurers to disclose only the necessary personal information they have on the deceased to the same persons or organizations specified in paragraph c.

The information provided on this form is protected from unauthorized disclosure under *Canada's Privacy Act* and is available to you upon request. A photocopy of this authorization shall be as valid as the original.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_.

Witness \_\_\_\_\_ Claimant \_\_\_\_\_

**9. SISIP FS Representative who assisted in the completion of this form**

Name	_____	Date	_____
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