

Claimant's Statement Regarding Death

Group Policy Number 901102

(Manulife use only)

Claim Number: _____

1. CERTIFICATE HOLDER'S INFORMATION

Service Number (SN)	
Surname	First Name

2. ADMINISTRATIVE INFORMATION:

Is/was the certificate holder's spouse or former spouse a CAF member? Yes* No ***If Yes, indicate name and Service Number of person** _____ and SN: _____

3. BENEFICIARY'S / CLAIMANT'S INFORMATION

Surname	First Name	Date of Birth (dd-mm-yyyy)	Social Insurance Number (SIN)
Apt.	Civic #	Street	City
Province	Postal Code	Primary/Day Telephone	Secondary/Evening Telephone
Relationship to the deceased person		Email Address	

4. DECEASED (Please check appropriate box)

Serving Member Spouse Child/Dependant
 Former Member Former Spouse Deemed Member

5. DECEASED'S INFORMATION

Surname	First Name	Date of Birth (dd-mm-yyyy)
Address at time of death (Only enter address if different from claimant)		
Place of Death (If hospital or institution, give name)	Date of Death (dd-mm-yyyy)	

6. CAUSE OF DEATH

a) What was the official cause of death? Specify:

b) Accidental Death:
Was this death an accidental death? Yes* No ***If Yes, please have the Attending Physician's Statement (APS) Regarding Death form (8E) completed by a doctor for this claim.**

c) Illness:
Was this death a result of an illness? Yes No

i. When did deceased first complain or give indications of illness?

dd	mm	yyyy
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 Specify: _____

ii. When did deceased first consult a physician for illness?

dd	mm	yyyy
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 Specify: _____

iii. When was the diagnosis of disease or condition made?

dd	mm	yyyy
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 Specify: _____

d) Stillbirth: Indicate weight in grams _____. Indicate number of weeks into pregnancy _____.
Was this death a stillbirth? In order to be considered a stillbirth, gestation must be at least **twenty (20)** weeks.
 Yes* No ***If Yes, please have the Attending Physician's Statement (APS) Regarding Death form (8E) completed by a doctor for this claim.**

7. COMPLETE FOR DEPENDANT LIFE CLAIMS ONLY

Was the dependant:

a Student?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Married?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent on you for financial support?	<input type="checkbox"/> Yes* <input type="checkbox"/> No	<i>*If Yes, please provide proof of the financial support with this claim. (i.e., confirmation of coverage under the member's medical/dental benefits plan, etc.)</i>
Employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Mother's first and last name:	Father's first and last name:	

8. DECEASED'S PHYSICIAN INFORMATION

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

Name	Address	Telephone	Fax

9. EMAIL CONSENT (if applicable)

I would like to correspond by email with Manulife about my claim. I authorize Manulife to correspond with me at the email address listed in Block 3. Correspondence may contain my personal information including, but not limited to, medical, employment and financial information.

Yes Initials: _____ No

10. SIGNATURE (to be read and signed for all submissions)

Declaration and authorization by claimant

The responses and declarations contained herein are true and complete. I realize that any material misrepresentation will render void this claim. I hereby authorize SISIP Financial and Manulife or its reinsurers, for underwriting and administration of insurance and claims paying purposes only:

- I understand the completion of this form is not an admission of any liability on the part of SISIP Financial or Manulife;
- to gather only that information necessary for the object of the file, from any person or organization that has personal information relating to me, including other insurers, physicians and medical institutions, the Medical Information Bureau (MIB*), investigation and credit reporting agencies, and all persons or organizations likely to have personal information relevant to the object of the file;

- to disclose only the necessary personal information it has relating to me to these same persons and organizations, specified in paragraph (a); or,
- to request a personal investigation report relating to me.

A copy of this authorization shall be as valid as the original. This authorization is valid for the period required to achieve the ends for which it was requested.

The information provided on this form is protected from unauthorized disclosure under Canada's Privacy Act, Personal Information Protection and Electronic Documents Act (PIPEDA) or equivalent provincial legislation and is available to you upon request.

Dated at _____ this _____ day of _____ 20_____ .

Claimant's Name Printed:

Claimant's Signature:

*MIB - to review information on your file, or have it corrected, visit www.mib.com for contact information.

11. SISIP FINANCIAL REPRESENTATIVE who assisted in the completion of and/or reviewed this form

Name	Signature	dd	mm	yyyy	Branch