La Capitale

CLAIMANT'S STATEMENT

1.	Contract number(s)	.....
2.	Full name of deceased	(Date of birth) (..... / ..... / .....)
3.	Address at time of death	
4.	Marital status at time of death	Single ☐ Married ☐ Widow(er) ☐ De facto separated ☐ Legally separated ☐ Divorced ☐
5.	If the deceased was married, separated, divorced or a widow(er), please provide the name of the most recent spouse.	
6.	Did the deceased have (Answer *Yes* or *No* to each question. If *Yes*, indicate the date of the document in question.)	A will? *Yes ☐ No ☐ Date: * If so, attach copies of the will. A marriage or civil union contract? Yes ☐ No ☐ Date:
7.	Did you request a will search? If so, attach copies of the will search certificates.	Yes ☐ No ☐ If so, attach copies of the will search certificates.
8.	Did the deceased leave any surviving children?	Yes ☐ No ☐ (If *Yes*, how many? ..... Ages.....)
9.	Date and place of death (if a hospital, specify name and address) – Attach the original proof of death	Date : ..... Location: .....
10.	Immediate cause of death:	
11.	Did the deceased use tobacco in any form?	Yes ☐ Since ..... / ..... / ..... Daily use (number) ..... No ☐ Had the deceased ever used tobacco in the past?: Yes☐ No ☐ If *Yes*, when did the deceased stop using tobacco? : ..... / ..... / .....
12.	When did the deceased begin to show signs or symptoms of poor health?	When did the last illness begin?
13.	When did the deceased first consult with a physician in connection with the last illness?	
14.	When did the deceased go to work at his or her regular place of employment for the last time?	(Last occupation.....)

15 Names and addresses of physicians who treated the deceased during the last three years and hospitals to which the deceased was confined.

	Name	Address	Date	Illness
a)	.....	.....	.....	.....
b)	.....	.....	.....	.....
c)	.....	.....	.....	.....

16. Details of other policies on the life of the deceased, held with other insurance companies:

Name of the company	Date of the contract	Amount	Name of the company	Date of the contract	Amount
.....	.....	.....	.....	.....	.....

17.	In what capacity are you making this claim?	Beneficiary ☐ Legal heir ☐ Executor ☐ Legal guardian ☐ Other ☐ _____
18.	What is your date of birth? ...../...../.....	Social Insurance No : ..... (will be used for tax purposes only)

I, the undersigned, hereby certify that the answers to the above questions are true and complete to the best of my knowledge. I understand that these answers shall be considered as valid as if they had been provided under oath.

_____
Signature of witness

_____
Date

_____
Signature of claimant

_____
Address of claimant

_____

Tel.: _____

La Capitale Civil Service Insurer Inc.
La Capitale Insurance and Financial Services Inc.
625 St-Amable St., P.O. Box 16040, Quebec QC G1K 7X8

La Capitale

ATTENDING PHYSICIAN'S STATEMENT

ATTENDING PHYSICIAN'S STATEMENT (All answers must be provided by the physician)		
1. Full name of the deceased		
2. Apparent age of the deceased		
3. Did you treat the deceased during his/her final illness?		
4. To the best of your knowledge, was the deceased using tobacco in any quantity?		
5. When did the deceased show the first symptoms of his/her illness?		
6. Dates of first and last consultation concerning final illness	First consultation:	Last consultation:
7. Date and place of death	Date: Place:	
8. Illness which was the cause of death		
9. What other illnesses may have contributed to death? (Give duration)		
10. Were any operations performed? If so, give date and type of operation.		
11. Was an autopsy performed? If so, by whom and what were the results?		
12. Was there a police investigation? If so, by whom and what were the results?		
13. (a) Did you treat the deceased or did he/she consult you before his/her final illness? (b) If so, give dates and illnesses.	(a) ---------- (b) ----------	
14. (a) In the past five years, was the deceased treated by other physicians or in any hospital? (b) If so, give names of physicians or hospitals, dates attended and nature of illness.	(a) ---------- Name of physician or hospital / Date attended / Nature of illness (b) ---------- ---------- ----------	
15. Additional information: (Use reverse if necessary)	----------	

I, the undersigned, certify that the answers to the above questions are true and complete and to the best of my knowledge.

_____ Date

_____ Physician's signature

_____ Name of physician (Please print) and licence number

_____ Physician's address

N.B. The claimant is responsible for any fees relating to this report.

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MEDICAL AUTHORIZATION

625 Saint-Amable St.
P.O. Box 16040
Quebec QC G1K 7X8
418 644-4106 or 1 888 703-4480
Fax: 418 643-8597 or 1 866 375-9780

To be filled in by the claimant

Last name and first name of deceased or individual on disability

Last name _____ First name _____

I, the undersigned, hereby authorize you to provide the Insurer's Medical Director with a certified true copy of the complete medical records and any information concerning medical treatment given to the above-named person including consultations, treatments, surgeries, etc.

The following persons or organizations are authorized to provide the above information:

a. physician
b. medical specialist
c. chiropractor
d. psychologist
e. pharmacist
f. optometrist
g. any individual, according to the law bound by Professional Secrecy
h. any establishment where such persons practise
i. any establishment within the meaning of the Act Respecting Health Services and Social Services
j. any government body or agency
k. any compensation board
l. any insurance company
m. any other organization, institution, establishment or individual holding records or information on the above individual:
   - Régie des rentes du Québec
   - Régie de l'assurance maladie du Québec
   - Commission de la santé et de la sécurité du travail
   - Commission administrative des régimes de retraite et d'assurances
   - Société de l'assurance automobile du Québec
n. the employer of the deceased or individual on disability

To be filled in and signed by the claimant

I authorize the request of information in my capacity as _____

(Specify: policyholder, insured, beneficiary, legal heir, executor, etc.)

Policy Number(s) _____

Signed at _____ this ____ day of _____ 20 ____ .

Witness _____ Signature of claimant

A copy of this authorization shall have the same force and effect as the original.