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?	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 five 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.
625 Jacques-Parizeau St, P.O. Box 16040, Quebec QC G1K 7X8