

200, rue des Commandeurs Lévis (Québec) G6V 6R2 www.desjardinslifeinsurance.com 1-800-278-0669



- This form must be filled out by the designated beneficiary or, in the absence of a beneficiary, the executor.
- If the beneficiary is incapacitated or a minor, this form must be filled out by their guardian or representative.
- If there is more than one beneficiary, each must fill out a form.
- Death certificate must be attached to the completed form.
- You can send us copies of the documents for your claim. If we need the originals, we'll let you know.
- · For deaths that occurred outside Canada or the United States, the originals are required.
- We won't send the originals back to you unless you ask us to in writing.

For internal use				
Last name of first insured		First name of first insured		
FC No.		FSA No.		
Policy No.	Effective date		Sum insured	
Please indicate your instructions by selecting one of the follo	wing 2 options:		\$	
Send cheque to advisor for delivery				

Send cheque directly to beneficiary(ies)



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

A. Information about	the deceased				
Last name		First nam	e		Sex
Address – No., street, apt.		City		Province	Postal code
Date of birth (YYYY-MM-DD)	Place of birth		Occupation		
Civil status of the deceased:	I				
Single	Married Joined in civil	union	Common-law spouse	Widowed	
Separated - if applicable, wit	h judgment or agreement on (YYYY-MM-DD)				
Divorced on (YYYY-MM-DD)					
Name of surviving spouse:					
Surviving children:	How many: Age(s):				
Surviving parent(s):	Father Mother Age(s):				
Surviving brother(s) and sister(s	s): How many: Age(s):				
Please answer the questions be	low and enter the date on which the docume	ent was produc	ed (if applicable). Did the deceas	sed have:	
a will*?	a marriage contract?		an act of civil union?	a declaration of	heredity*?
Yes No	Yes No)
Date (YYYY-MM-DD)	Date (YYYY-MM-DD)		Date (YYYY-MM-DD)	Date (YYYY-MM-	DD)
* See definition on page 5					
1. Date of death (YYYY-MM-DD)	2. Place of death		3. Immediate cause of de	ath	
4. a) When did the deceased be	egin to show signs of ill health?				
b) When did the last illness o	f the deceased begin?				
c) When was a physician cor	nsulted, for the first time, as to the last illness	of the deceas	sed?		
5. When did the deceased go to	work, for the last time, at his usual occupation				
6. Name and address of all phys	sicians who treated the deceased during the	last two years			

a) Did the deceased ever smoke?	b) When did the deceased start to smoke?	c) When did the deceased stop smoking?	d) Specify non-smoking periods
Yes No	(YYYY-MM-DD)	(YYYY-MM-DD)	

8. Did the deceased hold other life insurance contracts

Yes No If yes, please provide the following:

a) with other companies					
Name of life insurance comp	anies	Date of policies	Policy num	nbers	Sums insured
				\$	
				\$	
				\$	
 b) with Desjardins Insurance: Loan insurance with a caisse or credit unit 					
If yes, name of the institution:					
Transit No.: Account	No.:				
Accirance, Personal Accident Insurance:	Yes No				
• Group insurance with employer:	No				
If yes, name of employer:					
Name of insurance company:				Cont	ract No.:
Other: Yes No If yes, please specify:					
B. Information about the claima	nt				
Last name (or business name)	First name		Date of bi	rth (YYYY-MM-DD)	10-digit telephone Nos. Home
Address – No., street, apt.	City	Prov	ince	Postal code	Work
Occupation (or nature of business if an entity)					
Social insurance No. (Required so that any taxable in	iterest paid to the bene	ficiary can be reported)	Email add	ress	
In what capacity are you requesting payment of	the death benefit?				
Designated beneficiary Exe	ecutor of the estate	/ Liquidator of the successi	on		
	stee or guardian for				
Administrator of the business – Please specify th	-				
Other, please specify:					
What is your relationship to the deceased?					
	parated spouse				
Current spouse Separated spouse Child Parent					
Other (friend, business partner, etc.) – please					
Which settlement option do you wish?	specity.				
	an annuity contrac	t - policy number, if applica	ble		
C. Information about the execut	or of t <u>he esta</u>	ate			
Last name			name		
Address – No., street, apt.	City	Provi	nce	Postal code	10-digit telephone No.
Email address	I	I		1	

 \Box The executor of the estate / liquidator of the succession is also the claimant.

 $\hfill\square$ I do not know the the executor of the estate / liquidator of the succession.

CC	onsent related to the managemen	it of your personal information by Desjarding Insurance		
Ţ	Since this claim relates to a deceased pe	erson, the personal information required for this consent is that of the deceased person and not the claimant.		
1.	Why Desjardins Insurance needs your consent	 Your consent allows us to collect, use and disclose the personal information we require to: Analyze your insurance applications Manage your file while you're covered under the insurance Process claims Your consent also allows us to do the following, as required: Look at information in any old insurance file you may have with Desjardins Insurance Ack a personal information in any old insurance file you may have with Desjardins Insurance 		
		 Ask a personal information broker to provide us with an investigation report about you, if necessary Send a summary of your personal information, including health-related information, to MIB, LLC (see text box below), after analyzing an insurance application you've submitted 		
		MIB, LLC is an organization that operates a database allowing insurance companies in Canada and the United States to collect and disclose information about their clients.		
		 Send your doctor any medical information that we obtained about you when analyzing your insurance applications or claims, so they can share it with you 		
		 Provide insurers and reinsurers with any relevant information (medical test results, etc.), so they can assess an insurance application you've submitted 		
		By giving your consent to us, you also authorize our reinsurers to collect, use and disclose your personal information the same way we would. Our reinsurers are companies that insure us, Desjardins Insurance.		
2.	Who your personal information will be collected from or disclosed to	You give your consent for the collection and disclosure of the necessary information with you, but also with other people and organizations. These people and organizations include:		
		• MIB, LLC		
		Healthcare professionals or establishments (doctors, hospitals, clinics, etc.)		
		Healthcare providers		
		Paramedical firms		
		Public or parapublic organizations		
		Insurance companies other than Desjardins Insurance		
		Reinsurers		
		Your employer or a former employer		
		The policyowner (also called policyholder or contract holder), if you aren't that person		
		Other Desjardins components, if they're involved in the insurance		
		A personal information broker or an investigation firm		

Consent related to the management of your personal information by Desiardins Insurance

By signing this form, you:

• Authorize Desjardins Insurance and its reinsurers to collect, use and disclose your personal information based on the conditions outlined in this section, the applicable regulations and Desjardins Group's Privacy Policy. You can consult the policy at www.desjardins.com/privacy-policy

E. Déclarations

By signing this form:

- I request payment of the policy proceeds and I agree that all written statements of any physician who has examined or treated the deceased, as well as any other supporting document, are an integral part of this claim.
- I certify that all the answers given above are complete and true.

F. Signatures

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Signature of the beneficiary or the executor of the estate / liquidator of the succession

Χ

Signature of claimant

Date (YYYY-MM-DD)	

X

Signature of witness

Date (YYYY-MM-DD)

Date (YYYY-MM-DD)

Definitions

Declaration of heredity (Quebec only)

In the absence of a will, this document is prepared by a notary and identifies the deceased and lists their marital status, matrimonial regime (if applicable) and heirs. It can also serve the secondary purpose of designating a liquidator. It is used by institutions such as banks, Desjardins caisses and insurance companies, as well as government authorities.

Liquidator / Legal personal representative

Person designated by the testator, by the court or, in certain provinces, by the heirs to liquidate a succession.

Will

A revocable act in which a person (called a testator) determines how his or her property will be distributed upon death. Wills must meet the requirements for one of the will types recognized by law, i.e., holograph, in the presence of witnesses or notarial (Quebec only).

Will made in the presence of witnesses

A will:

- written by the testator or a third party; and
- dated and signed by the testator or a third party, depending on the province, before 2 or more witnesses.

It must be probated upon the testator's death.

Notarial will (Quebec only)

A will drawn up by a notary and signed by the testator, the notary and a witness. It does not need to be probated.

Holograph will

An entirely handwritten will dated and signed by hand by the testator. No witness is necessary. This type of will must be probated upon the testator's death.

Testator

Person who has made a will.