FINANCIÈRE SISIP FINANCIAL
A division of CFMWS
Une division des SBMFC

Claimant's Statement Regarding Death

Group Policy Number 901102

Manulife

(Manulife use only)
Claim Number: ______________________

1. CERTIFICATE HOLDER'S INFORMATION

Service Number (SN)	*Date of Enrollment (DOE) (dd-mm-yyyy)*
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

	dd	mm	yyyy	Specify:
i. When did deceased first complain or give indications of illness?				
ii. When did deceased first consult a physician for illness?				
iii. When was the diagnosis of disease or condition made?				

d) Stillbirth:
Was this death a stillbirth? In order to be considered a stillbirth, gestation must be at least **twenty (20)** weeks.
Incidate wight: _____ in grams; and,
# of weeks _____ into pregnancy.
☐ 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?	☐ Yes ☐ No	☐ Full-time ☐ Part-time
Married?	☐ Yes ☐ No	
Dependent on you for financial support?	☐ Yes* ☐ No	***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.)*
Employed?	☐ Yes ☐ No	☐ Full-time ☐ 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 BLOCK (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:

a) I understand the completion of this form is not an admission of any liability on the part of SISIP Financial or Manulife;

b) 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;

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

d) 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:**	
Witness' Name Printed:		**Witness' 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*