Industrial Alliance Insurance and Financial Services Inc.
iA Special Markets (Claims Department)
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Proofs of Death — Claimant's Statement

In furnishing this or other claims forms for the convenience of the claimant the company does not admit any liability or waive any of its rights.

Please Provide The Following Information Regarding The Deceased

Policy number(s) of each policy under which a claim is being made

Full name of deceased

Residence address

Date of birth (D D M M M Y Y Y Y)

Date of death (D D M M M Y Y Y Y)

Cause of death

Place of death

Place of birth

Occupation

Names And Addresses Of All Physicians Who Attended The Deceased In The Past 5 Years

Name	Address	Date	Reason
Family doctor		D D M M M Y Y Y Y	
Other physicians		D D M M M Y Y Y Y	
		D D M M M Y Y Y Y	

Facts Concerning Other Life And Accident Insurance On The Life Of The Deceased

Name of Company	Date of Policy	Amount of Insurance
	D D M M M Y Y Y Y	
	D D M M M Y Y Y Y	

This Section To Be Completed By Each Designated Beneficiary Of This Policy

Beneficiary's name (please print)

Soc. Ins. No. / Tax Ident. (IRS) No.

Mailing Address (in full)

Postal or ZIP code

Phone number

Email address

Are you 18 years of age or over? ☐ Yes ☐ No If No, give Date of Birth (D D M M M Y Y Y Y) (Please provide a copy of Minor's Birth Certificate)

Relationship to Deceased: _____

In what capacity or by what title do you claim the insurance proceeds?

☐ Beneficiary ☐ Executor ☐ Assignee ☐ Other (Specify): _____

Claimant's name (if different from the beneficiary) _____ Address _____

Phone number _____ Email address _____

I declare that the information provided in the Claimant's Statement is accurate and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as the result of this claim.

Dated at _____ This _____ (Day) Day of _____ (Month) Year _____ (Year (4 Digits))

_____ Witness

_____ Signature of Claimant

Authorization

As the personal representative of the Insured, I CONSENT to release the information contained in this Claim Form to Industrial Alliance Insurance and Financial Services Inc. (the "Company") and ACKNOWLEDGE that this information will be used to assess, process and administer this claim and policy coverage. I AUTHORIZE any other insurers, reinsurers, and financial institutions; physicians, medical institutions and healthcare providers; employers or administrators of group benefits; agents or brokers; investigating and credit reporting agencies, and all persons or organizations likely to have personal information relevant to the death claim of the life insured, to disclose this information to the Company.

I AUTHORIZE the Company to exchange the information detailed in this Claim Form and other information contained in files related to this claim or coverage with any of the parties identified in the previous paragraph for the purposes listed above, or as authorized by me, or as legally required.

I confirm that a photocopy or electronic copy of this authorization shall be valid as the original.

☐ EXECUTOR ☐ ADMINISTRATOR ☐ BENEFICIARY

☐ OTHER: _____

_____ Signature of Authorized Representative

Date Signed (D D M M M Y Y Y Y)

Please Return With Death Certificate ***IF YOU WOULD LIKE THE DEATH CERTIFICATE RETURNED TO YOU CHECK HERE*** ☐