Death Claim

Knowledge First Financial – Group Policy 83028

Please PRINT clearly.

Instructions

- The person filing the claim must complete Section 2 and attach a Certified Death Certificate and have a physician complete Section 3.
- Knowledge First Financial must complete Section 1.
- Once this form is complete, please return the original of this form to: Sun Life Assurance Company of Canada, Group Life Claims, PO Box 6075 Stn CV, Montreal QC H3C 3G5.

1 Savings information

This section must be completed by Knowledge First Financial

Deceased information

Deceased's last name	First name	Middle initial	☐ Male ☐ Female
Last mailing address (street name and number, apartment or suite)			
City	Province	Postal code	
Date of birth (dd-mm-yyyy) – –	Date of death (dd-mm-yyyy) – –	Age	

Agreement details

Identification	Frequency	Date of first Claimed Deposit (dd-mm-yyyy) – –	Date of last Claimed Deposit (dd-mm-yyyy) – –
Insurance effective date (dd-mm-yyyy) – –	Amount claimed $	Claimed deposits	Amount per deposit $

I certify that all the above statements are full, complete and true to best of my knowledge.

Name (please print)	Signature X	Date (dd-mm-yyyy) – –

2 Next of kin statement

This section must be completed by the person filing the claim.

Your relationship to the deceased	Date the deceased first complained of, or consulted a physician for, his/her last illness (dd-mm-yyyy) – –

To the best of your knowledge, has the deceased ever used any tobacco products? ☐ Yes ☐ No

Please provide the names and addresses of attending physicians of the deceased and hospitals where deceased was treated during the three years prior to death:

Name	Address	Date (dd-mm-yyyy)	Medical condition
		– –	
		– –	
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2 Next of kin statement (continued)

I certify that the information is true and correct. I authorize Sun Life Assurance Company of Canada, the plan administrator(s), and their agents and service providers to collect, use and disclose information needed for underwriting, administration and adjudicating claims under this insurance policy relating to____________________________ the life insured) with any person or organization who has relevant information pertaining to this claim including health professionals, government agencies, provincial health care plans, institutions, investigative agencies, insurers and reinsurers. I understand that information pertaining to this claim may be reviewed in the event that this plan is audited.

I agree that a photocopy of this authorization or electronic version is as valid as the original and shall remain in effect for the duration of the claim adjudication.

Name of deceased's authorized representative	Relationship to deceased (e.g., next of kin, executor/executrix, etc.)	
Address (street name and number)		Unit or suite
City	Province	Postal code
Signature of authorized representative X	Telephone number – –	Date (dd-mm-yyyy) – –

3 Physician's statement

This section must be completed by a physician.

Deceased's last name	First name	Middle initial
Date illness began (dd-mm-yyyy) – –	Date of death (dd-mm-yyyy) – –	Place of death
Immediate cause of death		
Contributory cause of death		

Was death due to: ☐ Natural causes ☐ Suicide ☐ Accident ☐ Homicide

To best of your knowledge, has the deceased ever used any tobacco products? ☐ Yes ☐ No

Did you treat or advise the deceased during the 3 year period preceding death? ☐ Yes ☐ No

If yes, please provide details (dates, illness/injury):

Did the deceased, to your knowledge, receive treatment during the last 3 years from any other physician, health practitioner, or in any hospital or institution? ☐ Yes ☐ No

If yes, please provide details:

Date (dd-mm-yyyy)	Name of physician/hospital	Address	Details
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3 Physician's statement (continued)

Name of physician (please print)		
Address (street name and number, apartment or suite)		
City	Province	Postal code

Telephone number	Fax number
– –	– –

To the best of my knowledge and belief, the above statements are true and complete.

Signature of physician	Date (dd-mm-yyyy)
X	– –

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