# Election of method of settlement and statement of claim

Sun Life Financial

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

## 1 Information about the deceased

Is the deceased the:

☐ Member ☐ Spouse ☐ Dependent

| Deceased's last name | First name | |
|---|---|---|
| Address (street number and name) | | Apartment or suite |
| City | Province | Postal code |
| Social Insurance Number | Date of birth (dd-mm-yyyy) | Marital status at death |
| Cause of death | Relationship to member (if not member) | |

## 2 Member information

| Policy number | Social Insurance Number | Member ID number |
|---|---|---|
| Member's last name | First name | Date of birth (dd-mm-yyyy) |
| Address (street number and name) | | Apartment or suite |
| City | Province | Postal code |

**If death occurred within two years of the date of coverage becoming effective or increased, please complete the following:**

Name and address of all Physicians who attended the deceased in the past five years.

| Name and addresses | Date (dd-mm-yyyy) | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Name and addresses of all hospitals or institutions where the deceased was treated in the past five years.

| Hospital/Institution | City/Town | Date (dd-mm-yyyy) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## 2 Member information (continued)

Please attach newspaper clippings; Coroner's report and/or Police report, if available.

Are you claiming an accidental death benefit? ☐ Yes ☐ No

If yes, please describe the circumstances surrounding the death.

| |
|---|
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| |

| Name of police officer | Name of police station |
|---|---|
| Automobile registration number | Driver's Licence number |

## 3 Information about the claimant

Please PRINT name. Please attach an original death certificate or a certified copy. A Physician Statement is required, if death occurred within two years of the date of coverage becoming effective or increased; and/or for any optional benefit exceeding $250,000 where the benefit has been in effect less than five years.

| Claimant's last name | First name | |
|---|---|---|
| Claimant's address (street number and name) | | Apartment or suite |
| City | Province | Postal code |
| Claimant's telephone number | | Claimant's Social Insurance Number |
| Claimant's date of birth (dd-mm-yyyy) | Relationship to deceased | |

Claimant's basis of claim

☐ Named beneficiary ☐ Trustee ☐ Beneficiary's Guardian

☐ Estate Representative ☐ Other, please specify _____

☐ I elect a lump sum payment ☐ Please arrange for an advisor to contact me at _____

## 4 Authorization and signature

I authorize Sun Life Assurance Company of Canada, the plan administrator(s), and their advisors and service providers to collect, use and disclose information needed for underwriting, administration and adjudicating claims under this insurance coverage 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.

A photocopy or electronic version of this authorization shall be as valid as the original.

I consent to the use of my Social Insurance Number for tax-reporting purposes in connection with this claim.

| Location signed (city) | Location signed (province) | Date (dd-mm-yyyy) | Claimant's signature |
|---|---|---|---|
| | | | X |
| Address (street number and name) | | | Apartment or suite |
| City | Province | | Postal code |
| Telephone number (home) | Telephone number (office) | | |

**Please return the fully completed form and supporting documents to:**

Sun Life Assurance Company of Canada
Attn: Group Life Claims
1155 Metcalfe
Montreal QC H3B 2V9