SSQ Financial Group
Values in the right place

SSQ Evolution
Subsidiary of SSQ Financial Group

Death Claim
Claimant's Statement

1610, Bellefeuille street, suite 201, Trois-Rivières, QC G9A 6H7

Policy No.: _____

INSTRUCTIONS
1. Fill out the claimant's Statement, sign the authorizations below.
2. Have the back filled out by the physician.
3. All costs incurred are at the claimant's expense.

1. IDENTIFICATION OF THE DECEASED PERSON

SURNAME AND FIRST NAME	DATE OF BIRTH Y Y Y Y M M D D	MARITAL STATUS AT DEATH ☐ Single ☐ Married ☐ Divorced ☐ Widowed
ADDRESS AT TIME OF DEATH		
PREVIOUS ADDRESS IF LESS THAN TWO YEARS		

2. INFORMATION ON THE DECEASED PERSON

1. DOES THE PERSON HAVE CHILDREN? ☐ Yes ☐ No	2. DATE OF DEATH Y Y Y Y M M D D	3. PLACE OF DEATH
4. WAS DEATH DUE TO ☐ an accident ☐ a murder ☐ suicide ☐ natural death	5. DESCRIBE IT BRIEFLY:	
6. WAS THERE AN INVESTIGATION? ☐ Yes ☐ No		7. WAS THERE AN AUTOPSY? ☐ Yes ☐ No
8. IF YES, INDICATE BY WHOM AND PROVIDE THE OBSERVATIONS		
9. DID THE PERSON HAVE A MARRIAGE CONTRACT? ☐ Yes ☐ No		10. DID THE PERSON HAVE A WILL? ☐ Yes ☐ No
11. WHEN DID THE DECEASED PERSON BEGIN TO SHOW SYMPTOMS OF POOR HEALTH? Y Y Y Y M M D D		
12. WHEN DID THE FINAL ILLNESS BEGIN? Y Y Y Y M M D D	13. WHAT IS THE DATE OF THE FIRST MEDICAL VISIT FOR THE FINAL ILLNESS? Y Y Y Y M M D D	

14. WAS THE DECEASED PERSON TREATED OR HOSPITALIZED OVER THE LAST TWO YEARS?

NAMES OF PHYSICIANS OR HOSPITALS	DATE	REASON

15. NAME AND ADDRESS OF THE FAMILY PHYSICIAN

16. INDICATE ANY OTHER INSURANCE POLICIES ON THE LIFE OF THE DECEASED PERSON

NAMES OF COMPANIES	DATES OF POLICIES	AMOUNTS

3. TOBACCO USE

1. DID THE DECEASED PERSON USE TOBACCO? ☐ Yes ☐ No	2. IF NOT, DID THE PERSON SMOKE PREVIOUSLY? ☐ Yes ☐ No	3. IF YES, ON WHAT DATE DID THE SMOKING END? Y Y Y Y M M D D

4. IDENTIFICATION OF THE CLAIMANT

Surname and first name	Date of birth Y Y Y Y M M D D	Relationship with the deceased person
Address: _____ Tel: _____		ON WHAT BASIS ARE YOU MAKING THIS CLAIM? ☐ Beneficiary ☐ Liquidator ☐ Other: _____

I, the undersigned, hereby certify that the answers to the questions above are recorded correctly and that they are full, complete and truthful, to the best of my knowledge. I state that they have the same value as if they were made under oath.
(ALL COSTS INCURRED IN FILLING OUT THIS FORM ARE AT THE CLAIMANT'S EXPENSE.)

Witness's signature	Date Y Y Y Y M M D D	Claimant's signature
X		**X**

IMPORTANT – DATE AND SIGN THE AUTHORIZATIONS AND SEND THEM TO THE COMPANY

AUTHORIZATION	AUTHORIZATION
I hereby authorize any health care professional, doctor, hospital, clinic, insurance or reinsurance company, or any other public or private organization or institution that holds information on the deceased person, in particular information on this person's state of health, medical history, treatments received or any other information concerning this claim, to provide this information to SSQ, Life Insurance Company Inc. its legal agents, services providers and reinsurers, to enable it to analyze this claim made under the insurance policy bearing the number below as well as the validity of this policy. I also authorize SSQ, Life Insurance Company Inc. and its legal agents to exchange this information with other insurance or reinsurance companies or service providers for the analysis of this claim. A photocopy of this authorization will have the same value as the original.	I hereby authorize any health care professional, doctor, hospital, clinic, insurance or reinsurance company, or any other public or private organization or institution that holds information on the deceased person, in particular information on this person's state of health, medical history, treatments received or any other information concerning this claim, to provide this information to SSQ, Life Insurance Company Inc. its legal agents, services providers and reinsurers, to enable it to analyze this claim made under the insurance policy bearing the number below as well as the validity of this policy. I also authorize SSQ, Life Insurance Company Inc. and its legal agents to exchange this information with other insurance or reinsurance companies or service providers for the analysis of this claim. A photocopy of this authorization will have the same value as the original.
Liquidator's or beneficiary's signature	Liquidator's or beneficiary's signature
Insurance policy no. Date Y Y Y Y M M D D	Insurance policy no. Date Y Y Y Y M M D D

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Death Claim
Attending Physician's Statement

1610, Bellefeuille street, suite 201, Trois-Rivières, QC G9A 6H7

Policy number: _____

ANY CHARGE FOR COMPLETING THIS FORM IS THE CLAIMANT'S RESPONSIBILITY.

1. IDENTIFICATION OF DECEASED

FULL NAME OF DECEASED	DATE OF DEATH (Y Y Y Y M M D D)
ADDRESS OF RESIDENCE AT DEATH	
PLACE OF DEATH (*If hospital or institution, give name*)	AGE AT DEATH / BIRTH DATE (Y Y Y Y M M D D)

2. INFORMATION RELEVANT TO THE DECEASED

Cause of death – (Enter only one cause for each of a, b, and c)	**Interval between onset and death**
a) Disease or condition directly leading to death (This does not mean the mode of dying such as heart failure, asthenia, etc. It means the disease, injury or complication which caused death).	
b) Previous causes (Morbid conditions, if any, giving rise to the above cause stating the underlying cause last).	
c) Due to (or as a consequence of)	
OTHER SIGNIFICANT CONDITIONS (Contributing to the death but not related to the disease or condition causing death.)	
DATE OF FIRST ATTENDANCE IN FIRST ILLNESS (Y Y Y Y M M D D)	DATE OF LAST ATTENDANCE IN LAST ILLNESS (Y Y Y Y M M D D)
CAUSE OF DEATH ☐ Accident ☐ Homicide ☐ Suicide	DESCRIBE BRIEFLY:

HAS THERE BEEN AN INQUIRY? (*If yes, please indicate by whom and write observations*)
☐ Yes ☐ No

HAS THERE BEEN AN AUTOPSY? *(If yes, please indicate by whom and write observations)*
☐ Yes ☐ No

DID THE DECEASED RECEIVE TREATMENT DURING THE LAST TWO YEARS FROM ANY OTHER PHYSICIAN? *(If yes, please write physician's name and address)*
☐ Yes ☐ No

	YES	**NO**
Have you treated the above mentioned person or did she consult you during the two years preceding her last illness?	☐	☐
To your knowledge, during the last two years, has this person taken any prescription drugs for her illness?	☐	☐
To your knowledge, during the last two years, has this person been treated by another doctor, or in an institution or hospital?	☐	☐

IF YOU HAVE ANSWERED YES TO EITHER ONE OF THESE QUESTIONS, PLEASE GIVE THE FOLLOWING INFORMATION:

NAME	ADDRESS	
NATURE OF ILLNESS	NAME OF DRUGS	DATES
SIGNATURE OF PHYSICIAN **X**	ADDRESS OF PHYSICIAN	DATE