DEATH CLAIM
CLAIMANT'S STATEMENT

This claim form is provided by Industrial Alliance Insurance and Financial Services Inc. and its affiliate Industrial Alliance Pacific Insurance and Financial Services Inc. ("the companies") for the convenience of the claimant and is intended to be used to submit claims for Life Insurance. In furnishing this or other claim forms, the Companies do not admit any liability or waive any of their rights.

For any claims of $50,000 or under for contracts of more than 10 years, the F55 21A(2) may be used.

1. Authorized Agent	Agency & Code	S.U.

INFORMATION CONCERNING THE DECEASED

2. Contract(s)	3. Amount	4. Plan

5. Last name

6. First name

7. No. 8. Street 9. Apt.

10. City 11. Province 12. Postal code

13. Occupation of the insured 14. Social Insurance Number 15. Date of birth Y M D

16. When did deceased's health first begin to decline? 17. Date of first medical attendance for the last sickness? Y M D 18. Date of death Y M D

19. Place of death 20. Cause of death

21. Names and addresses of doctors who attended the deceased during the last sickness or the past five years.

Name of doctor	Address	Date (Y M D)	Sickness or condition

22. Names and addresses of hospitals where deceased was hospitalized during the past five years.

Name of hospital	Address	Date (Y M D)

23. MARITAL STATUS OF DECEASED

☐ Single ☐ Married ☐ Widowed
☐ Common Law spouse, since ____________________

OR

MARRIED BUT AT TIME OF DEATH:

☐ Divorced since ____________________ ☐ Marriage annulled
☐ Legally separated since ______________ ☐ Separated in fact only

24. Did the deceased leave any children? ☐ No ☐ Yes How many? Ages?

25. How many brothers and sisters did the deceased have? Ages?

26. Indicate whether or not the deceased's parents are still living: Father? ☐ No ☐ Yes Mother? ☐ No ☐ Yes

27. Details of other insurance policies (life, accident, sickness) on the life of the deceased with other insurers.

Name of insurer	Policy number	Date of policy (Y M D)	Amount
			$
			$

INFORMATION CONCERNING THE CLAIMANT (Read instructions on the following page)

28. Last and first name 29. Relationship to deceased 30. Date of birth Y M D 31. Social Insurance Number

32. Address No. Street Apt. City Province Postal code

33. In what capacity are you making this claim?

☐ Beneficiary (Indicate all addresses for beneficiaries who live abroad.) ☐ Estate ➔ Payment will be made in the name of the estate.

34. I request that the settlement be

☐ transferred to contract ____________________ (application enclosed) ☐ paid in a lump sum (cheque).

I declare that the information provided in this claim 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.

I consent to release the information contained in this claim form to Industrial Alliance Insurance and Financial Services Inc. or its affiliate Industrial Alliance Pacific Insurance and Financial Services Inc. (the Companies) 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 benefit, agents or brokers, investigating and credit reporting agencies, and all persons or organizations likely to have personal information relevant to this claim to provide it to the companies.

I authorize the companies to exchange the information detailed in the 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 as valid as the original.

Witness ____________________ Claimant ____________________ Date ____________

Address of witness ____________________ Address of claimant ____________________ Date ____________

Home phone no. Work phone no.

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INSTRUCTIONS

The form must be signed by the beneficiary. When there is more than one beneficiary, the form may be signed by only one of the beneficiaries, but you must indicate the addresses and social insurance numbers of each beneficiary on a separate sheet. A cheque will be issued in the name of each beneficiary, unless you advise us to make a single cheque for all beneficiaries.

When the beneficiary designation is "legal heirs", or "estate", the executor or the administrator of the estate (Common Law Provinces) or the liquidator of the estate (Quebec) or one of the heirs must sign the form and the cheque will be made in the name of the estate.

If any of the beneficiaries are minors, the form must be completed by the tutor (Quebec) or by a designated trustee (other provinces). Attach a birth certificate for minor beneficiaries and indicate the parents' names and addresses. The payment will be made according to applicable legislation.

If the insured amount has been fully or partially assigned, the benefit will be paid jointly to the assignee and the beneficiary. If the assignment is no longer in effect, send us a copy of the release or retrocession.

If you would like further information concerning the form or your claim, please contact your representative or the Claims Department.

Note – Use form F37-14A for a death claim involving an individual annuity contract.

For a contract insuring several lives, if the deceased is the owner of the contract and no contingent owner has been designated, the declaration below must be completed.

DECLARATION

I, ______________________________, residing

at number __________ street ______________________ in ______________

declare the following:

1. ______________________________ died at ______________
   on ______________________________ at the age of ______________

2. I am the ______________________________ of the deceased.
   (widower, widow, brother, sister, etc.)

3. The deceased was ❑ owner of policy no(s). ______________________
   issued by **Industrial Alliance Insurance and Financial Services Inc.**

4. The deceased left the following testamentary disposition(s):

   a) a will ❑ Yes **Please enclose a copy of the will.** ❑ Notarized ❑ English form ❑ Holograph
   After having made a thorough search, I submit the enclosed document as the last will of the deceased person.
   ❑ No - Complete Section 5

   b) a marriage contract ❑ Yes - **Please enclose a copy** of the contract **and** complete Section 5
   ❑ No

   If the answers to 4a and 4b were **negative**, complete Section 5.

5. Spouse's name ______________________________ ❑ Legally married ❑ Common Law spouse

   Spouse's date of birth: Y | M | D

   Did the deceased have any children? ❑ Yes - Complete Section 6 ❑ No - Complete Section 7

6. Children's last and first names

   ______________________ Born on: Y | M | D ______________________ Born on: Y | M | D
   ______________________ Born on: ______________________ Born on:
   ______________________ Born on: ______________________ Born on:

7. Relatives:

LIVING		Next of kin	DECEASED	
Name	Age		Name	At age
		Father		
		Mother		
		Brothers/Sisters		
		Brothers/Sisters		

I declare that these answers are true and I understand that the declaration is made for the purpose of transferring ownership of the contract.

Signed at ______________________________

this ______________ day of ______________ 20 ______ ______________________________
Signature

____
Witness

____
Address