

## PROOF OF CLAIM

### STATEMENT OF CLAIMANT

1. **a.** Name of deceased in full \_\_\_\_\_ **b.** Date of birth \_\_\_\_\_
- c.** Residence of deceased \_\_\_\_\_ **d.** Occupation of deceased \_\_\_\_\_
2. Date of death \_\_\_\_\_
3. What was the immediate cause of death? \_\_\_\_\_
4. When did deceased first consult a physician for their last illness? \_\_\_\_\_
5. CUMIS policy/certificate number(s) under which you are claiming \_\_\_\_\_
6. **a.** NAME OF DECEASED'S FAMILY DOCTOR \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
No Street City Province Postal Code
- b.** NAME OF PREVIOUS FAMILY DOCTOR \_\_\_\_\_  
 (If above has not been deceased's doctor for the past 3 years)  
 ADDRESS \_\_\_\_\_  
No Street City Province Postal Code
7. NAME OF SPECIALIST \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
No Street City Province Postal Code
8. **a.** In what capacity or by what title do you make this claim? \_\_\_\_\_
- b.** What is your date of birth? \_\_\_\_\_ **c.** Your Social Insurance Number \_\_\_\_\_

CERTIFICATION: I hereby certify that the above answers are full, complete and true, to the best of my knowledge.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

Name of Claimant \_\_\_\_\_ Signature \_\_\_\_\_

Address of Claimant \_\_\_\_\_ Phone Number: Area Code ( \_\_\_\_\_ ) \_\_\_\_\_

Name of Witness \_\_\_\_\_ Signature \_\_\_\_\_

Address of Witness \_\_\_\_\_

### AUTHORIZATION FOR RELEASE OF MEDICAL AND EMPLOYMENT INFORMATION

I authorize any physician, hospital, insurer, employer or any other organization or person having any records, data or information concerning \_\_\_\_\_, to furnish such records, data or information as may be requested to the CUMIS Life Insurance Company.

I understand that the personal information furnished herein will be used by CUMIS for claims administration purposes, and for such other lawful purposes in accordance with applicable federal and provincial laws, as may apply.

A photocopy of this Authorization shall be considered as effective and valid as the original.

I hereby waive any privilege with respect to such information.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_ .

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
RELATIONSHIP TO DECEASED