CUMIS Life Insurance Company
P.O. 5065, 151 North Service Rd., Burlington, Ontario L7R 4C2
Tel: (905) 632-1221 / 1-800-263-9120 Fax: (905) 632-4886 / 1-800-897-7065
Service en français
Tél: 1-800-361-3936 Télécopieur: 1-800-897-7065

CUMIS®

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