AUTOMOBILE ACCIDENT BENEFITS PROOF OF CLAIM FORM

(For use in Quebec with Q.E.F. 34 & 78 not for use in Ontario. Ontario has regulated AB forms.)

(Death Only)

This claim form to be completed by the Claimant and the Attending Physician and should be returned to the Insurance Company, with the following documents as indicated.

BIRTH CERTIFICATE ☐ MARRIAGE CERTIFICATE ☐

THIS SIDE TO BE COMPLETED BY THE CLAIMANT ONLY. CLAIM NO. .....

I, ..., residing at .....

telephone ..... do hereby make claim under Policy No. ..... issued by..... to .....

based on the following.

DECEASED PERSON

Name ..... Address.....

Marital Status..... Sex ..... Date of Birth.....

Occupation..... Employer's Name .....

Employer's Address ..... Telephone .....

Was the deceased in the course of his/her employment when the accident occurred? .....

Was the deceased covered by any Workers' Compensation Act? ....

CLAIMAINT AND BENEFICIARIES

What is your relationship to the deceased? .....

Were you principally dependent on the deceased?... .....

List dependent children for whose support the deceased was legally liable

Name	Date of Birth	Address	Relationship to Deceased
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Name and address of the Executor or Administrator of the deceased's Estate? .....

.....

Name and address of the Lawyer representing the deceased's Estate? ....

.....

CAR INVOLVED

Make ..... Year ..... Type of Body..... Licence No. .....

Owner's Name ....Owner's address..... .....

Driver's Name .....Age.....Driver's address..... .....

Is this car insured by any other automobile policy? .....

If so, state Insurer's Name and Policy Number . ...

.....

ACCIDENT DETAILS:

Date ..... Time ..... Location ....

Was the deceased in the car described above?..... ....

Was the deceased a pedestrian when struck by the car described above? .....

What date did the death occur? .....

Was the death caused **directly** by the accident?..... ....

....

Date _____ Claimant's Signature _____

CERTIFICATE OF ATTENDING PHYSICIAN OR SURGEON AT TIME OF DEATH

Please complete this form in every detail and return it to the Claimant indicated on the reverse side.

I hereby certify that I examined the under-mentioned for death resulting from an accident, and that particulars thereof are as follows:

1. Name of Deceased ....Date of Birth .....

2. Last Address .....

3. Date and time and Place of death .....

4. Type of Accident .....

5. Date, Time and Place of Accident .....

6. Where first examined after the accident and by whom.....

7. Nature and extent of injuries involved .....
   .....
   .....

8. Who was the Deceased's usual physician? (If known).....

2. Was the death caused by or in any way due to a previous injury, illness, or condition?.....

3. In my opinion death was cause by .....
   .....

4. Was an inquest held? .... If so, where and when? .....

12. Was an autopsy performed? ..... If so, by whom and with what findings? .....
    .....

Signature of
Physician or Surgeon .....

Date .....

Address.....
.....
.....

Vehicle VIN #| | | | | | | | | | | | | | | | |

Any fee for the above report to be paid by the Claimant