Print Reset

CLAIMANT'S STATEMENT – DEATH CLAIM

POLICY NUMBER(S) – Please provide a number of each policy under which a claim is being made.

PERSONAL DETAILS

DECEASED'S NAME

DATE OF DEATH (DAY / MONTH / YEAR)

CAUSE OF DEATH

PLACE OF DEATH

PROVINCE OR STATE OF DOMICILE

DATE AND PLACE OF BIRTH

CLAIM AND RELATED DETAILS

Please provide names and addresses of all physicians, hospitals or institutions where the insured person was treated in the past 5 years:

NAME	ADDRESS	DATE	REASON

Is death the result of: an illness ☐ or an accident ☐?

If death was due to an illness:

Date symptoms of illness began

Date of diagnosis of illness

Date the insured was advised of the diagnosis

Name and address of the doctor who made the diagnosis

Did the insured ever smoke? YES ☐ NO ☐ If YES, when did the insured last smoke?

CLAIMANT'S DETAILS

CLAIMANT'S NAME

SOCIAL INSURANCE NUMBER

CLAIMANT'S ADDRESS

POSTAL CODE

Are you 21 years of age or over? ☐ YES ☐ NO If NO, please give the date of birth D M Y

In what capacity or by what title do you claim the insurance? (e.g. named beneficiary, executor, assignee)

What is your relationship to the insured?

PHONE

Do you wish the proceeds to be: ☐ Placed on deposit or ☐ Paid in lump sum

CONSENT & DISCLOSURE REGARDING PERSONAL INFORMATION

I consent to Wawanesa Life collecting, using and disclosing my personal information for the purposes of: establishing and maintaining communications with me; investigating and paying claims; detecting and preventing fraud; offering and providing products and services to meet my needs; compiling statistics and acting as required or authorized by law.

I understand that Wawanesa Life may share my personal information with the following people, organizations and service providers: Wawanesa Life employees and agents who require this information to perform their jobs; third party providers who require this information to provide their services to you, which may include claims investigators, investigative agencies, providers of information processing and storage, programming, printing, mailing and distribution services; applicable reinsurance companies; people to whom I have granted access; and people who are legally authorized to view my personal information. These people, organizations and service providers may be in other provinces or in jurisdictions outside Canada. My information may be shared as required by the laws of those jurisdictions.

I understand that any restriction or withdrawal of my consent may result in Wawanesa Life being unable to process the claim being applied for.

You can obtain further information about Wawanesa Life's Personal Information Protection Policy and practices concerning service providers outside Canada from the Wawanesa Life Executive Office at 400-200 Main Street, Winnipeg, MB R3C 1A8 or at www.wawanesalife.com.

If you have a question (including a question concerning our collection of personal information, or the collection, use, disclosure or storage of personal information by service providers outside Canada on our behalf) or complaint regarding our privacy policies or procedures, please contact the individual accountable for our personal information protection compliance: Privacy Officer, The Wawanesa Life Insurance Company, 400-200 Main Street, Winnipeg, Manitoba R3C 1A8.

AUTHORIZATIONS / DECLARATIONS / SIGNATURES

I hereby declare that the foregoing answers are true and complete; that, to the best of my knowledge and belief, I have withheld no material facts from the Company and that the foregoing answers and statements are made with the object of securing the benefit claimed.

I confirm that I have read, understood and accepted the terms and conditions contained in the Consent & Disclosure Regarding Personal Information.

I authorize all physicians and other persons who have attended the deceased and all hospitals, institutions and government authorities to furnish to the Wawanesa Life Insurance Company all information in their possession or within their knowledge respecting the deceased.

A photocopy or an electronic reproduction of this document will be as valid as the original.

Dated at _____ this _____ day of _____, _____

_____ WITNESS

_____ SIGNATURE OF CLAIMANT

In furnishing this or other claims forms for the convenience of the claimant, the Company does not admit any liability or waive any of its rights.

PLEASE RETURN FORM TO:
The Wawanesa Life Insurance Company
400 – 200 Main Street, Winnipeg, MB R3C 1A8
TOLL FREE: 1-888-997-9965 FAX: 1-888-985-3872 WEBSITE: wawanesalife.com

LIMITATION PERIOD NOTICE

Every action or proceeding against the Company for a recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation. Limitation period can be suspended if the claimant provides satisfactory evidence that their disability prevented them from taking action within the Limitation Period.