ACE INA Insurance
ACE INA Life Insurance
1400 – 25 York Street
Toronto, Ontario M5J 2V5
Telephone: 416-594-2627 1-877-772-7797

PROOF OF ACCIDENTAL DEATH
CLAIMANT'S STATEMENT

(ATTACH CERTIFIED COPY OF DEATH CERTIFICATE)
PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

Policy No. _____

1.	Full name of Deceased		
2.	Full address of the Deceased at death: Street		
	City	Province	Postal Code
3.	Date of birth of Deceased		
4.	Place, date and time of death		
5.	(a) Occupation of Deceased at death		
	(b) Name and address of Employer		
6.	(a) On what date did the accident occur?	(b) Approximate time of accident	
	(c) Specifically, where did the accident occur		
7.	How did the accident occur? (answer fully)		
8.	Who was present at the time of the accident? (Witness)		
	Please list names and addresses		
9.	What injury or injuries were sustained?		
10.	Was an Autopsy or Inquest held?		
	If yes, give the name and address of Coroner and attach a copy of the report if available to you		
11.	Were the police called to the scene of the accident?		
	If yes, give the name of the agency called and attach a copy of the report if available.		
12.	(a) State name and address of the doctor or Hospital that first attended after the injury		
	(b) Also, name and address of the doctor or hospital that attended the Deceased at the time of death		

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13. Did the Deceased have a family doctor? If yes, give the doctor's name and address	
14. Did the deceased see a doctor for an injury or sickness in the last two years? If yes, when and what for?	
Give doctor's name and address	
15. Did the Deceased carry any other Accident or Life Insurance?	
If so, state name of the Insurer	
Address	
Policy Numbers	
Amounts carried	
16. (a) What is your full name?	(b) Date of Birth
(c) Relation to the Deceased?	
17. Your Social Insurance # (required for tax purposes)	
18. Remarks	

CLAIMANT'S CERTIFICATION: The above statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered without refund of any premiums paid. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

PRIVACY NOTICE: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by ACE INA Insurance and/or ACE INA Life Insurance, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about the insured, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. The Insurer will establish a claims file to which access will be restricted to authorized employees and agents of the Insurer and to persons authorized by law. If I have the right to access the information, access will be given to me or such persons I may authorize.

AUTHORIZATION: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with ACE INA Insurance/ACE INA Life Insurance, or representatives thereof, all personal health information, benefit payment or financial information about the insured or any other information or records about the insured in its possession that is requested while administering this claim.

I agree that a photocopy of this authorization shall be as valid as the original.

Full Mailing Address of Claimant: Street		
City	Province	Postal Code
Phone # of Claimant ( )		

Signature of Claimant _____ Date _____