Chubb Life Insurance Company of Canada (“Chubb Life”)
Chubb du Canada Compagnie d’Assurance-Vie (« Chubb-Vie »)

for Term 10 to Age 85 Life Insurance Policy underwritten by
Chubb Life/Chubb-Vie and administered and distributed by
Combined Insurance Company of America/Compagnie d’assurance Combined d’Amérique

Term 10 to Age 85 Life Insurance
Proof Of Death • Claimant’s Statement

PART A – INFORMATION ABOUT THE DECEASED

Policy Number(s)	Form Number(s)

Last Name	First Name
Date of Birth (MM/DD/YYYY)	Date of Death (MM/DD/YYYY)
Address	
City / Province	Postal Code
Place of Death	Cause of Death
Did the deceased use any form of tobacco products? Yes ☐ No ☐	If so, what type of tobacco? Amount per day?
Did the deceased ever stop smoking? Yes ☐ No ☐	If yes, when? For how long?

List the companies with which the deceased had Life, Accidental, and/or Health Insurance

Company Name	Effective Date of Insurance	Amount of Insurance

Name of Primary Physician	Phone # of Physician ( )
Address of Physician	

List any other physicians, hospitals or institutions where the deceased was treated in the past 5 years.

Physician/Health Provider’s Name	Addresses and contact numbers	Reason for visit	Dates

PART B – INFORMATION ABOUT THE CLAIMANT

Last Name	First Name
Address	
City / Province	Postal Code
Date of Birth (MM/DD/YYYY)	Payee Social Insurance Number (for tax-reporting any interest on claims paid)
Work Phone # ( )	E-mail Address:
Cell Phone # ( )	Home Phone # ( )
You are claiming as (check one box only)	Beneficiary ☐ Estate’s Executor ☐ Trustee ☐ Other ☐
If other, please specify	
Did the deceased leave a Will?	Yes ☐ No ☐ Unknown ☐
Signature of Claimant	Date (MM/DD/YYYY)
Relationship to the deceased	

PART C –DECLARATIONS AND SIGNATURES

CLAIMANT'S CERTIFICATION: I represent and affirm that the information that I provided in this claim form, is true and complete to the best of my knowledge and belief. If at any time, I become aware that the information herein is inaccurate or incomplete, I will immediately notify Chubb Life/Chubb-Vie. I understand that any person who knowingly, and with intent to defraud any insurance company or other persons, files a claim containing false information or conceals any fact material thereto, commits a fraudulent insurance act, which is a crime that is subject to criminal prosecution, civil penalties and any other penalties available at law. 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 Chubb Life/Chubb-Vie, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

AUTHORIZATION: I authorize Chubb Life/Chubb-Vie, its reinsurers and authorized administrators (the "Insurer"), and its employees and agents, to acquire from, and authorize any hospital, doctor, medical practitioner, clinic, medically related facility, person who has examined the deceased, insurance company, 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 to and exchange with the Insurer, and its agents and employees, all information, including but not limited to personal health information, benefit payment or financial information about the deceased, or any other information or records about the deceased in its possession that is requested while administering this claim. I also authorize the Insurer, and its employees and agents, to disclose all such information to other persons or entities as may be required to evaluate this claim.

This authorization shall remain valid for the duration of this claim investigation.

Signature of Claimant	Date (MM/DD/YYYY)

Print Name

PROTECTING YOUR PERSONAL INFORMATION: Your privacy is important to us. We may leverage our strengths in our worldwide operations and our relationships with service providers to help us provide customers with the best service we can provide. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions.

To find out about our Privacy Policy, visit our website at https://www2.chubb.com/ca-en/privacy-policy.aspx, or to obtain information about our privacy practices, send a written request to: Privacy Officer, Chubb Life/Chubb-Vie, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, ON M5L 1E2.

Send this completed form to our Administrator, Combined Insurance Company of America/Compagnie d'assurance Combined d'Amérique at:

P.O. Box 3720 MIP
Markham, ON L3R 0X5

Toll free number: 1 888 234-4466

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Term 10 to Age 85 Life Insurance
Proof Of Death • Physician's Statement

PART A – PROOF OF DEATH PHYSICIAN'S STATEMENT INFORMATION ABOUT THE DECEASED	
Policy Number(s)	Form Number(s)

Last Name	First Name	
Date of Birth (MM/DD/YYYY)	Date of Death (MM/DD/YYYY)	
Address		
City	Province	Postal Code
Place of Death		
Date of first visit relating to the last illness (MM/DD/YYYY)		
Date of the last visit relating to the last illness (MM/DD/YYYY)		
Did the deceased use any form of tobacco products? Yes ☐ No ☐	If so, what type of tobacco?	Amount per day?
Did the deceased ever stop smoking? Yes ☐ No ☐	If yes, when?	For how long?
Disease or condition leading to death:		
Immediate cause of death (disease, injury or complication causing death)		
Time between onset and death		
Antecedent causes, as well as the date of onset of other significant conditions.		
If death due to cancer, please give date of diagnosis of primary cancer. (MM/DD/YYYY)		
List any other significant conditions (morbid conditions) whether or not related to the cause of death		
Was death due to: Accident ☐ Suicide ☐ Homicide ☐ None of the above ☐		
Briefly describe		
Was autopsy performed? Yes ☐ No ☐	Who performed the autopsy?	
What were the results of the autopsy?		
Have you treated or advised the deceased during the last 3 years, prior to last illness?		Yes ☐ No ☐
Did the deceased, to your knowledge, receive treatment during the last 3 years from any other physician, or in any hospital or institution?		Yes ☐ No ☐

If "Yes" to either question above, please furnish the following:

Name	Address	Nature of Illness or injury	Dates (MM/DD/YYYY)

PART B – DECLARATIONS AND SIGNATURES

I declare that the information I have provided herein is complete and true to the best of my knowledge. If at any time, I become aware that the information herein is inaccurate or incomplete, I will immediately notify Chubb Life/Chubb-Vie.

Name of Physician	
Phone # of Physician ( )	Fax # of Physician ( )
Address of Physician	
Signature of Physician	Date (MM/DD/YYYY)

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Markham, ON L3R 0X5

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