

For any claims of \$30,000. or under for contracts of more than 10 years, the F55 21A(2) may be used.

1. Agent	Agency & Code	S.U.
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INFORMATION CONCERNING THE DECEASED

2. Contract(s)	3. Amount	4. Plan	5. Last name
			6. First name
			7. No.
			8. Street
			9. Apt.
			10. City
			11. Province
			12. Postal code

13. Occupation of the insured	14. Social Insurance Number	15. Date of birth
		Y M D
16. When did deceased's health first begin to decline?	17. Date of first medical attendance for the last sickness?	18. Date of death
	Y M D	Y M D
19. Place of death	20. Cause of death	

21. Names and addresses of doctors who attended the deceased during the last sickness or the past five years.			
Name of doctor	Address	Date	Sickness or condition
		Y M D	

22. Names and addresses of hospitals where deceased was hospitalized during the past five years.		
Name of hospital	Address	Date
		Y M D

23. **MARITAL STATUS OF DECEASED**

Single Married Widowed **OR** Divorced since _____ Marriage annulled

Common Law spouse, since _____ Legally separated since _____ Separated in fact only

24. Did the deceased leave any children? No Yes How many? Ages?

25. How many brothers and sisters did the deceased have? Ages?

26. Indicate whether or not the deceased's parents are still living: Father? No Yes Mother? No Yes

27. Details of other insurance policies (life, accident, sickness) held by the deceased with other insurers.			
Name of insurer	Policy number	Date of policy	Amount
		Y M D	\$
			\$

INFORMATION CONCERNING THE CLAIMANT (Read instructions on reverse side)

28. Last and first name	29. Relationship to deceased	30. Date of birth	31. Social Insurance Number
		Y M D	
32. Address No. Street	Apt. City	Province	Postal code

33. In what capacity are you making this claim?

Beneficiary (Indicate all addresses for beneficiaries who live abroad.) Estate → Payment will be made in the name of the estate.

34. I request that the settlement be

transferred to contract _____ (application enclosed) paid in a lump sum (cheque).

I hereby declare that the above answers are true and complete, that I have withheld no important information and that the above answers and statements are made with the object of securing payment to me of the proceeds for the above-mentioned contract. If any of these statements are false, I will be subject to legal proceedings and I agree in such a case to reimburse any sums received in connection with this claim.

I hereby authorize any insurer or employer, and any physician, surgeon or other person who has previously examined or treated the late _____ or hospital or other institution where he/she sought and received treatment, to reveal to

Industrial Alliance Insurance and Financial Services Inc. or its duly authorized representative, all information that is on record or that has been obtained about him/her.

A photocopy of this authorization shall be as valid as the original.

Witness	Claimant	Date
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Address of witness	Address of claimant	Date
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Home phone no. _____ Work phone no. _____

