Desjardins Insurance
Life • Health• Retirement

200, rue des Commandeurs
Lévis (Québec) G6V 6R2

DEATH CLAIM
EMPLOYER'S STATEMENT

PRINT RESET

Settlement of this claim will be possible only if an adequate answer is given to all questions of this form.

A. Identification of employee

Last name of insured	First name of insured	Date of birth
		YYYY-MM-DD

B. Identification of individual concerned (if other than the employee)

Last name of individual concerned	First name of individual concerned	Date of birth
		YYYY-MM-DD

C. Identification of employer

Name of employer		
Address - No., Street		
City	Province	Postal code
Telephone number Ext. Area code + number	Plan administrator's email address	
Contract/Group No.	Account/Division No.	Identification No.

D. Employer's statement

1. Date of hiring YYYY-MM-DD	2. Coverage effective date YYYY-MM-DD	
3. Was the insured disabled before the event? ☐ Yes ☐ No	4. Date of beginning of disability YYYY-MM-DD	
5. Last date worked YYYY-MM-DD	6. Salary at beginning of disability	7. Annual salary at the date of the event

8. Return the payment to employer: ☐ Yes ☐ No

9. Benefit claimed :

☐ Life $ _____ ☐ Supplemental/Optional life $ _____ ☐ Dependent life $ _____

Remarks

E. Declaration

Declaration – I declare that the information provided above is complete and true.

_____ _____
Name of employer's representative (please print) **Title**

_____ _____
Signature of employer's representative **Date**