

Return this form to:

Death and/or Funeral Benefits Application (OCF-4)

Use this form for accidents that occur on or after January 1, 1994

Claim Number

Policy Number

Date of Accident (yyyy/mm/dd)

This form must be completed by or on behalf of the spouse and dependant(s) of the deceased and any other person entitled to claim for purchased death and/or funeral benefits. If more than one person is applying for benefits, they can apply together or separately. If you have not done so, please complete the Application for Accident Benefits form. Attach a copy of the death certificate. **Please print clearly.**

Part 1 - Deceased's Information

Deceased's Last Name

Deceased's First Name and Initial

Address

City/Town

Province

Postal Code

Birth Date (yyyy/mm/dd)

Date of Accident (yyyy/mm/dd)

Date of Death (yyyy/mm/dd)

Marital Status

- ☐ Single ☐ Separated
☐ Married ☐ Divorced
☐ Common-law ☐ Widow(er)

Were there dependants at time of death?

☐ No ☐ Yes If yes, how many persons? _____

Death Certificate attached

☐ No ☐ Yes

Part 2 - Survivor Information

☐ (attach additional sheets if necessary)

If you are applying for death benefits, please indicate your relationship to the deceased.

Applicant 1

Last Name

First Name and Initial

Address

City/Town

Province

Postal Code

Home Telephone Number

Work Telephone Number

Fax Number

Relationship to deceased

- ☐ Spouse ☐ Parent ☐ Guardian ☐ Dependant
☐ Former spouse entitled to support
☐ Other person on whom the deceased was dependent (Specify) _____

Applicant 2

Last Name	First Name and Initial
-----------	------------------------

Address

City/Town	Province	Postal Code
-----------	----------	-------------

Home Telephone Number	Work Telephone Number	Fax Number
-----------------------	-----------------------	------------

Relationship to deceased

☐ Spouse ☐ Parent ☐ Guardian ☐ Dependant☐ Former spouse entitled to support☐ Other person on whom the deceased was dependent (Specify) _____**Applicant 3**

Last Name	First Name and Initial
-----------	------------------------

Address

City/Town	Province	Postal Code
-----------	----------	-------------

Home Telephone Number	Work Telephone Number	Fax Number
-----------------------	-----------------------	------------

Relationship to deceased

☐ Spouse ☐ Parent ☐ Guardian ☐ Dependant☐ Former spouse entitled to support☐ Other person on whom the deceased was dependent (Specify) _____**Part 3 - Funeral expenses**☐ (attach additional sheets if necessary)

Attach all original receipts. If a receipt is not submitted, please explain in the space provided below.

Date (yyyy/mm/dd)	Description of service and name of supplier or provider	Amount claimed
Total payment requested		

Part 4 - Signature

☐ (attach additional sheets if necessary)

Applicant 1

I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company. I further understand that the information contained on this form may be used and disclosed in the manner described in my Application for Accident Benefits.

Name of Applicant or Substitute Decision Maker	Signature of Applicant or Substitute Decision Maker	Date of Signature (yyyy/mm/dd)

Applicant 2

I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company. I further understand that the information contained on this form may be used and disclosed in the manner described in my Application for Accident Benefits.

Name of Applicant or Substitute Decision Maker	Signature of Applicant or Substitute Decision Maker	Date of Signature (yyyy/mm/dd)

Applicant 3

I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company. I further understand that the information contained on this form may be used and disclosed in the manner described in my Application for Accident Benefits.

Name of Applicant or Substitute Decision Maker	Signature of Applicant or Substitute Decision Maker	Date of Signature (yyyy/mm/dd)

Print Form

Clear Form

Save Form