Return this form to:

Death and 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: (YYYYMMDD)	

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 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				**Marital Status** ☐Single ☐Separated ☐Married ☐Divorced ☐Common-law ☐Widow(er)	
Deceased's First Name and Initial					
Address				**Were there dependants at time of death** ☐Yes, how many persons?…… ☐ No	
City		Province	Postal Code	**Death Certificate attached** ☐ Yes ☐ No	
Birth Date	(YYYYMMDD)	Date of Accident	(YYYYMMDD)	Date of Death	(YYYYMMDD)

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				**Relationship to deceased** ☐Spouse ☐Parent ☐Guardian ☐Dependant ☐Former spouse entitled to support ☐Other person on whom the deceased was dependent (Specify) ……	
First Name and Initial					
Address					
City		Province	Postal Code		
Home Telephone	Area Code	Work Telephone	Area Code	Fax Number	Area Code

Applicant 2

Last Name				**Relationship to deceased** ☐Spouse ☐Parent ☐Guardian ☐Dependant ☐Former spouse entitled to support ☐Other person on whom the deceased was dependent (Specify) ……	
First Name and Initial					
Address					
City		Province	Postal Code		
Home Telephone	Area Code	Work Telephone	Area Code	Fax Number	Area Code

Applicant 3

Last Name				**Relationship to deceased** ☐Spouse ☐Parent ☐Guardian ☐Dependant ☐Former spouse entitled to support ☐Other person on whom the deceased was dependent (Specify) ……	
First Name and Initial					
Address					
City		Province	Postal Code		
Home Telephone	Area Code	Work Telephone	Area Code	Fax Number	Area Code

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 (YYYYMMDD)	Description of Service and Name of Supplier or Provider	Amount Claimed
		$
		$
		$
		$
		$
		$
		$
	TOTAL PAYMENT REQUESTED	**$**

Details of missing bills or receipts

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 (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)

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 (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)

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 (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)