

Foreign death questionnaire



1 Policy details

Policy number(s)

2 Details about the deceased

First name	Middle name	Last name	Date of birth (dd-mm-yyyy)
Other names (if any)	Country of birth	City of birth	
Passport number	Date of issue (dd-mm-yyyy)	Place of issue	
Occupation			
Last address in Canada (street number and name)			Apartment or suite
City	Province	Postal code	Date deceased left Canada (dd-mm-yyyy)
Intended duration of visit	Purpose of the visit		
Airline used to depart from Canada	Flight number		
Airport of departure	Airport of arrival	Was a return flight booked? <input type="checkbox"/> Yes <input type="checkbox"/> No	
First name of deceased's doctor in Canada	Middle name	Last name	
Address (street number and name)			Apartment or suite
City	Province	Postal code	

3 Details of death

Exact place of death (address if other than hospital)	Date of death (dd-mm-yyyy)	
Cause of death		
First name of doctor who certified the death	Middle name	Last name

Hospital information

Hospital name			
Address (street number and name)			Apartment or suite
City	Province/State	Country	Postal/Zip code
Telephone number	Was there a post-mortem? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was there an inquest? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Foreign death questionnaire (continued)

3 Details of death (continued)

Accident (Complete if death is caused by an accident.)

Date of accident (dd-mm-yyyy)	Details of accident including time and how accident occurred.		
Did the police investigate? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'yes', is investigation open or closed? <input type="checkbox"/> Open <input type="checkbox"/> Closed	If 'yes', indicate type of accident and provide details of the investigation.		
Name of the police officer or police station who investigated the accident			Telephone number
Address (street number and name)			Apartment or suite
City	Province/State	Country	Postal/Zip code

Illness (Complete if death is caused by an illness.)

Date of first symptoms of illness (dd-mm-yyyy)	Nature of illness		
Name of physician who treated the patient for this illness			Telephone number
Address (street number and name)			Apartment or suite
City	Province/State	Country	Postal/Zip code

4 Burial/cremation

Was the deceased buried? <input type="checkbox"/> Yes <input type="checkbox"/> No	If 'yes', provide date of burial (dd-mm-yyyy)	Was the deceased cremated? <input type="checkbox"/> Yes <input type="checkbox"/> No	If 'yes', provide date of cremation (dd-mm-yyyy)
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Provide name and address of the funeral home or organization that handled the burial or cremation.

Name			
Address (street number and name)			Apartment or suite
City	Province/State	Country	Postal/Zip code

If burial or cremation took place outside of Canada, provide name and address of one person (not related to the deceased) that was a witness.

First name	Middle name	Last name	
Address (street number and name)			Apartment or suite
City	Province/State	Country	Postal/Zip code

5 Details of claimant

First name	Middle name	Last name	
Date of birth (dd-mm-yyyy)	Place of birth	Relationship to the deceased	

Foreign death questionnaire (continued)

6 Additional information

Attach all available documentation for any issued document shown below. **Note:** Ensure you provide an indication for each document.

Supporting documents	Attached	Will follow	Unavailable or not issued
Original passport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ticket information/travel itinerary/boarding pass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Death certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital records/receipts or other related documents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burial certificate/receipts or other related documents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cremation certificate/receipts or other related documents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transit permit (if body was returned to Canada)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Funeral home documentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Police report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coroner report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Provide any additional information that would assist in the verification of death.

7 Declaration

I, the claimant, declare that the information I have provided in this form is complete and true to the best of my information, knowledge and belief, and will be relied on by Sun Life Assurance Company of Canada to evaluate my claim.

Province signed	Date (dd-mm-yyyy)	Signature of claimant X	
Address (street number and name)			Apartment or suite
City			Province Postal code