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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 or Same-Sex Partner Status					
Deceased's First Name and Initial						<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Common-law <input type="checkbox"/> Widow(er)					
Address											
City				Province		Postal Code		Were there dependants at time of death			
								<input type="checkbox"/> Yes, how many persons? _____ <input type="checkbox"/> No Death Certificate attached <input type="checkbox"/> Yes <input type="checkbox"/> No			
Birth Date	year	month	day	Date of Accident	year	month	day	Date of Death	year	month	day

Part 2 Survivor Information

(attach additional sheets if necessary)

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

Last Name						Relationship to deceased					
First Name and Initial						<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Same-Sex <input type="checkbox"/> Guardian <input type="checkbox"/> Dependant Partner <input type="checkbox"/> Former spouse entitled to support <input type="checkbox"/> Other person on whom the deceased was dependent (Specify) _____					
Address											
City				Province		Postal Code					
Home Telephone	Area Code	Work Telephone	Area Code	FAX Number	Area Code						

Applicant 2

Last Name						Relationship to deceased					
First Name and Initial						<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Same-Sex <input type="checkbox"/> Guardian <input type="checkbox"/> Dependant Partner <input type="checkbox"/> Former spouse entitled to support <input type="checkbox"/> Other person on whom the deceased was dependent (Specify) _____					
Address											
City				Province		Postal Code					
Home Telephone	Area Code	Work Telephone	Area Code	FAX Number	Area Code						

Applicant 3

Last Name						Relationship to deceased					
First Name and Initial						<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Same-Sex <input type="checkbox"/> Guardian <input type="checkbox"/> Dependant Partner <input type="checkbox"/> Former spouse entitled to support <input type="checkbox"/> Other person on whom the deceased was dependent (Specify) _____					
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	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)
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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)
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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)
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