AIG Insurance Company of Canada
120 Bremner Boulevard, Suite 2200
Toronto, ON M5J 0A8
416-596-4005 | 1-877-317-8060
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CLAIMANT'S STATEMENT
Proof of Death

Please return completed form to AIG Insurance Company of Canada

Policyholder: **Province of New Brunswick**

Policy No.: ☐ **BSC 910-3557** ☐ **SUPP 910-3558** ☐ **VOL 910-3559**

1. a) Full name of the deceased: ____________________
   b) Residence at time of death: ____________________
   c) Occupation: ____________________ Employer's Name: ____________________

2. Date of Birth (M/D/Y): ____________________

3. a) Date of Death (M/D/Y): ____________________ Place of Death: ____________________
   b) Cause of Death: ____________________

4. a) Name and address of every doctor who attended or was consulted during the previous 3 years:
   ____
   ____
   b) Name and address of family physician: ____________________
   ____

5. a) Please provide your full name: ____________________
   b) Date of birth if under the age of 18 (M/D/Y): ____________ (please attach a copy of your birth certificate)
   c) Relationship to deceased: ____________________ S.I.N.: ____________________
   d) Capacity in which claim is being made: ☐ Beneficiary ☐ Executor ☐ Assignee ☐ Other __________

6. Please submit a death certificate along with this completed form.

PERSONAL INFORMATION NOTICE: I understand that the information provided on this claim form and otherwise in respect of this claim, is required by AIG Insurance Company of Canada, its reinsurers and authorized administrators (the "Insurer") to assess this claim, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and coordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files, collect additional information, and where required, collect information from and exchange information with, third parties.
CERTIFICATION: The statements provided in this claim form and otherwise in respect of this claim are true and complete to the best of my knowledge and belief.
AUTHORIZATION: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, including any group policyholder and employer, possessing records or knowledge of the late ______________________________ (the "Deceased") to release and exchange with AIG Insurance Company of Canada, or representatives thereof, all personal health information, benefit payment, employment or financial information about the Deceased or any other information or records about the Deceased in its possession that is requested while administering this claim. I am granting this authorization and direction in my capacity as ________________________________ and concerning my interests or rights in such capacity. I agree that a photocopy of this authorization shall be as valid as the original.

Signature: ____________________ Date (M/D/Y): ____________________
Address: ____________________ Phone Number: ____________________
Witnessed by: ____________________ Date (M/D/Y): ____________________

The submission of forms shall not be an admission of liability by the Company.