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Return this form to:			ı		Death and Funeral Benefits Application (OCF-4)			
					Use this	 form for accid	ents that occur on or after January 1, 1994	
					Claim Number:		•	
•			1		Policy Number:			
_					Date of Accident: (YYYYMMDD)			
more than one pe	erson is applyin its form. Attacl		pply together or				entitled to claim for benefits. If complete the Application for	
Part 1	Deceased's Last Name						Marital Status □ Single □ Separated □ Married □ Divorced □ Common-law □ Widow(er)	
Deceased's Information	Deceased's First Name and Initial							
	Address					Were there dependants at time of death ☐Yes, how many persons?		
	City		Province		Postal Code		rtificate attached Yes No	
	Birth Date	(YYYYMMDD)	Date of Accident		(YYYYMMDD)	Date of Death	(YYYYMMDD)	
Information ☐ (attach additional sheets if necessary)	Last Name First Name and Initial Address					Relationship to deceased Spouse Parent Guardian Dependant Former spouse entitled to support Other person on whom the deceased was		
	City		Province		Postal Code	depend	lent (Specify)	
	Home Are Telephone	a Code	Work Telephone	Area Code		Fax Number	Area Code	
	Applicant 2 Last Name First Name and Initial Address						Relationship to deceased Spouse Parent Guardian Dependant Former spouse entitled to support	
	City		Province		Postal Code	. –	erson on whom the deceased was dent (Specify)	
	Home Are Telephone	a Code	Work Telephone	Area Code		Fax Number	Area Code	
	Applicant 3			l				
	Last Name						Relationship to deceased	
	First Name and Initial						e	
	Address					☐ ☐ Former spouse entitled to support ☐ Other person on whom the deceased was		
	City		Province		Postal Code	depend	dent (Specify)	
	Home Are	a Code	Work	Area Code		Fax	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. Amount Description of Service and Name of Supplier or Provider Claimed (YYYYMMDD) \$ \$ \$ \$ \$ \$ \$ \$ **TOTAL PAYMENT REQUESTED** Details of missing bills or receipts **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

Part 4 Signature

☐ (attach additional sheets if necessary) 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)	