



1920 College Avenue,  
Regina, Saskatchewan,  
S4P 1C4

**NOTICE**  
**to**  
**CO-OPERATORS LIFE INSURANCE COMPANY**  
**HEAD OFFICE: REGINA, SASKATCHEWAN**  
**(to be completed by employer)**

of the death of \_\_\_\_\_

an employee or  a dependant\* of an employee of ours insured under Group Policy No. \_\_\_\_\_

issued by the Insurance Company.

We hereby warrant that the aforesaid employee/dependant died on the \_\_\_\_\_ day of \_\_\_\_\_

that the said employee/dependant was insured under the Group Policy at the date of death; that the

claimant \_\_\_\_\_ has personally signed at the foot of the second page and is the

beneficiary entitled to any Death Benefit as provided for in the said Group Policy.

Date employee entered our employment \_\_\_\_\_ Cert. No. \_\_\_\_\_

Date employee last reported for work \_\_\_\_\_ .

\* If claiming for a dependant, please provide proof of eligibility for dependant coverage.

Employer \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_ By \_\_\_\_\_

**(Signature)**

\_\_\_\_\_  
**(Official Title)**

**1. RETURN GROUP CERTIFICATE**

**2. ATTACH ATTENDING PHYSICIAN'S CERTIFICATE**

(Please complete reverse) →

**CLAIMANT'S STATEMENT  
(to be completed by claimant)**

1. Particulars regarding the DECEASED:

(a) Name (in full) \_\_\_\_\_

(b) Province of Legal Domicile \_\_\_\_\_

(c) Occupation \_\_\_\_\_

(d) Date of Birth \_\_\_\_\_

(e) Place of Birth \_\_\_\_\_

(f) Date of Death \_\_\_\_\_

(g) Place of Death \_\_\_\_\_

(h) Cause of Death (state details) \_\_\_\_\_  
\_\_\_\_\_

(i) Duration of last illness \_\_\_\_\_

(j) Name and address of each attending physician \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. In what capacity or by what title do you claim the insurance money?

\_\_\_\_\_  
**(Beneficiary, Executor, Assignee, etc.)**

3. Date of your birth? \_\_\_\_\_ Soc. Ins. No. \_\_\_\_\_

4. Are you legally entitled to receive the whole of the insurance moneys payable and to give a valid discharge therefor? \_\_\_\_\_

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I hereby declare that the above answers are true and full; that, to the best of my knowledge and belief, I have withheld no material facts from the Insurance Company and that the above answers and statements are made with the object of securing payment to me of the proceeds of the insurance.

I expressly consent, authorize and direct all physicians, and other persons and all hospitals, institutions and government authorities who have attended the deceased and every hospital or other institution to which the deceased has applied for, or in which the deceased has received treatment to disclose to the insurance company or its authorized representative any knowledge thereby acquired and to honor a photostatic copy of this authorization.

Claimant Signature \_\_\_\_\_ Claimant Name \_\_\_\_\_

**(please print)**

Address of Claimant \_\_\_\_\_ Postal Code \_\_\_\_\_  
(Street or Box) (City) (Prov.)

Telephone # \_\_\_\_\_

**STATEMENT OF WITNESS:**

**The claimant whose signature I have witnessed is known to me and signed this form in my presence.**

Date \_\_\_\_\_ Witness \_\_\_\_\_