

STATEMENT OF CLAIMANT
Beneficiary Entitlement

Name of Deceased: _____

Social Insurance Number: _____ Date of Birth: _____

Date of Death (attach proof): _____

Date Last Worked: _____

BENEFICIARY INFORMATION

Name: _____ Relationship: _____

Social Insurance Number: _____ Phone #: () _____

Date of Birth (attach proof): _____

Address: _____

_____ Postal Code: _____

METHOD OF PAYMENT:

 X LUMP SUM PAY-OUT

Date

Signature of Beneficiary

PLEASE RETURN THIS FORM WITH THE ORIGINAL DEATH CERTIFICATE (OR A NOTARIZED COPY)