Insurer Identification (Name and Address)	**Ontario Automobile Insurance Death and Funeral Payment Request**	
	Insurer No.	Claim No.
Name of Policy Holder	Date of Accident Year Month Day	Policy No. Claiming Under

Instructions

- This form should be completed by or on behalf of the deceased's spouse or dependants. If more than one person is claiming benefits, as spouse or dependant, they should claim together, but may claim separately if necessary.

1 Identity of Deceased

☐ Mr. ☐ Mrs. ☐ Ms. Last name	First name Mid. Init.	Date of Birth Year Month Day

Street Address P.O. Box or Rural Route Apt.

City, Town, Village	Province or State	Country	Postal / Zip Code

Date and Time of Death
Year Month Day Hour ☐ A.M. ☐ P.M.

Marital Status of Deceased
☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Common-law ☐ Widow(er)

2 Identity of Person Making Claim

Making Claim as

☐ Spouse ☐ Parent ☐ Guardian ☐ Dependant ☐ Lawyer ☐ Executor, Administrator or Trustee ☐ Other – specify:

☐ Mr. ☐ Mrs. ☐ Ms. Last name	First name Mid. Init.	Area Code – Telephone No.
Name of Firm/Organization (if applicable)		Area Code – Fax No.
Street Address P.O. Box or Rural Route		File Reference (if applicable)

City, Town, Village	Province or State	Country	Postal / Zip Code

3 Payment Requested

☐ Funeral (complete section 4) ☐ Dependants (complete section 5)
☐ Other (specify and complete section 4)

FSCO (1335E)

4 Details of Expenses – Attach original receipts

Item	Date	Description of Service and Name of Service Provider	Amount
		Total Amount	$

5 Deceased's Dependents

☐ Mr. ☐ Mrs. ☐ Ms. | Last name | First name | Mid. Init. | Date of Birth Year Month Day

Street Address | P.O. Box or Rural Route | Apt.

City, Town, Village | Province or State | Country | Postal / Zip Code

Area Code - Home Telephone No. | Area Code - Work Telephone No. | Language Preferred ☐ English ☐ French ☐ Other (specify)

Relationship to Deceased

☐ Mr. ☐ Mrs. ☐ Ms. | Last name | First name | Mid. Init. | Date of Birth Year Month Day

Street Address | P.O. Box or Rural Route | Apt.

City, Town, Village | Province or State | Country | Postal / Zip Code

Area Code - Home Telephone No. | Area Code - Work Telephone No. | Language Preferred ☐ English ☐ French ☐ Other (specify)

Relationship to Deceased

☐ Mr. ☐ Mrs. ☐ Ms. | Last name | First name | Mid. Init. | Date of Birth Year Month Day

Street Address | P.O. Box or Rural Route | Apt.

City, Town, Village | Province or State | Country | Postal / Zip Code

Area Code - Home Telephone No. | Area Code - Work Telephone No. | Language Preferred ☐ English ☐ French ☐ Other (specify)

Relationship to Deceased

Is there any other person who may be entitled to make a claim for these benefits?

☐ Yes ☐ No If Yes, please specify.

6 Declaration

I certify in good faith that the information provided is true.

Signature	Name of Person Signing (Please Print)	Date