

## Foreign Death Questionnaire

*(Failure to completely answer these questions may delay the claim. Please provide additional supporting documentation where required)*

Deceased Insured \_\_\_\_\_ Policy Number(s) \_\_\_\_\_

**1** What is the date of death of the deceased? \_\_\_\_\_  
(DD/MM/YYYY)

**2** What is the name of the country and city or town where death occurred?

\_\_\_\_\_

**3** What was the reason for the trip?

\_\_\_\_\_

\_\_\_\_\_

**4** Name and address of person(s) who accompanied the deceased insured:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**5** At what address did the deceased insured stay?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**6** With whom did the deceased insured stay?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**7** On what date did the deceased insured leave Canada? \_\_\_\_\_  
(DD/MM/YYYY)

**8** What was the deceased insured's itinerary?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Foreign Death Questionnaire**

---

**9** How long did the deceased insured intend to stay?

---

If death was the result of an **Illness**, please complete **Questions 10 to 15**.

If death was the result of an **Accident**, please proceed directly to **Question 16**.

---

**Illness:**

---

**10** What were the deceased insured's symptoms and when did they first occur?

---

---

---

**11** On what date did the deceased insured first consult a doctor overseas? \_\_\_\_\_  
(DD/MM/YYYY)

**12** On what date was the illness diagnosed? \_\_\_\_\_  
(DD/MM/YYYY)

**13** What was the diagnosis and treatment prescribed?

---

---

---

---

**14** Provide the name and address of the treating physician:

---

---

---

---

**15** What is this physician's specialty?

---

---

---

For **Illness**, please proceed to **Question 24**.

---

**Accident:**

---

**16** Please provide details of the accident (date, time, place): (DD/MM/YYYY) \_\_\_\_\_

---

---

**17** Were there any witnesses to the accident?    Yes    No

**Foreign Death Questionnaire**

---

**18** If death was instantaneous, who identified the deceased insured?

---

---

**19** Was the accident reported to the local authorities?    Yes    No

**20** Which authorities were advised?

---

---

**21** Was there an investigation conducted?    Yes    No

**22** What was the name of the investigating official? Please submit a copy of the accident report or police report.

---

**23** If hospitalized, who accompanied and admitted the deceased insured?

---

For **Illness** and **Injury**, please complete **ALL** remaining questions.

**24** Provide the name and address of the hospital.

---

---

---

---

**25** On what date was the deceased insured hospitalized? \_\_\_\_\_  
(DD/MM/YYYY)

**26** Name of person who paid the hospital bills and/or doctors' bills, and their relationship to the deceased insured? Please provide copies of any medical bills pertaining to treatment.

---

---

**27** Was an autopsy or inquest conducted?    Yes    No    Provide a copy of the Autopsy Report.

**28** Name of person who authorized the release of the body?

---

**29** Please select the method of disposal of the body:    Burial    Cremation

**30** Please provide name of establishment and date when this took place.    (DD/MM/YYYY) \_\_\_\_\_

---

**31** Name of person who carried out these duties, and where did this take place?

---

---

---

---

**Foreign Death Questionnaire**

---

**32** Who attended the ceremony?

---

---

---

**33** Provide names and addresses of two witnesses (not family members) who were present at the ceremony.

---

---

---

---

---

---

**34** Provide copies of the airline e-ticket used for travel and any documents (i.e. passport, visa and other) used by the deceased insured to enter that country.

**35** Name and address of the deceased insured's regular treating physician in Canada?

---

---

---

**These answers given above are true and complete to the best of my belief and understanding.**


Date: \_\_\_\_\_  
(DD/MM/YYYY)

\_\_\_\_\_  
Claimant's Signature

\_\_\_\_\_  
Name of Claimant (please print)



P.O. Box 4241, Station A, Toronto, ON M5W 5R3 • Telephone: 1-800-846-5970 • [claimsdepartment@ivari.ca](mailto:claimsdepartment@ivari.ca)

 **The fastest and easiest way to send us your completed and signed forms is through our online tool, *Send documents* on [ivari.ca](http://ivari.ca). By using this tool, forms are sent instantly and securely.**

™ ivari and the ivari logos are trademarks of ivari Holdings ULC. ivari is licensed to use such marks.