Sagicor

PROOF OF DEATH
(GROUP INSURANCE)

EMPLOYER'S STATEMENT

1. Name of the Employee:	2. Name of Dependent: (If Dependent coverage)
3. Residence of the Deceased:	
4. Master Policy No:	5. Certificate No: / 6. Amount of Insurance:
7 Date Employee last worked full time:	Day / Month / Year

8. Reason for termination of active, full time employment:

- ☐ Sickness or injury (describe) _____
- ☐ Granted leave of absence from _____ to _____
- ☐ Temporarily laid off from _____ to _____
- ☐ Other (specify) _____

_____

9. Due date of last premium paid with respect to the insurance of the deceased employee:

Day I Month I Year

10. Was Evidence of Insurability (EOI) required for coverage? ☐ Yes ☐ No

If no EOI was provided, please provide a Death Certificate that states the cause of death.
If EOI was provided, please submit an Attending Physician's Statement

Employer ..... By .....

Date ..... Title .....

CLAIMANT'S STATEMENT

1. Name of the Claimant (s) *(please print)*		
2. Name of the Deceased		
3. Date of Birth of the Deceased Day I Month I Year	4. Place of Birth of the Deceased	5. Cause of Death

6. a. In what capacity do you claim the death benefit? ☐ Beneficiary ☐ Executor ☐ Administrator ☐ Legal Guardian *(of minor beneficiary)*

a. Are you legally entitled to receive entire proceeds? ☐ Yes ☐ No

If no, to what portion are you entitled? _____

b. Who is entitled to the balance and in what proportion? _____

(If claiming as executor or administrator a certified copy of letters probate or administration is required).

I/We understand and agree that the furnishing of this form or the furnishing of any form supplemental hereto, does not constitute and will not be considered as a waiver of any of the Company's rights with respect to liability under the policy, or the identification of persons entitled to benefits payable hereunder or of any other rights or defences available to the Company.

I hereby authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, insurance company, or other person, organization, or institution, that has any records or knowledge of _____, Deceased, to give to Sagicor Life Inc or its representative, any such information. A photocopy of this authorization shall be as valid as the original.

Dated at _____ this _____ day of _____, 20_____

Witness Signature	Claimant's Signature	Relationship	Date of Birth (D/M/Y)
(Name in Block Letters)	(Name in Block Letters)	Address	Telephone No
Witness Signature	Claimant's Signature	Relationship	Date of Birth (D/M/Y)
(Name in Block Letters)	(Name in Block Letters)	Address	Telephone No
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