



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:
9. Due date of last premium paid with respect to the insurance of the deceased employee: Day Month Year
10. Was Evidence of Insurability (EOI) required for coverage? Yes No
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 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
a. Are you legally entitled to receive entire proceeds? Yes No
b. Who is entitled to the balance and in what proportion?
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

