Sagicor

PROOF OF DEATH
CLAIMANT'S STATEMENT

PLEASE ANSWER ALL QUESTIONS FULLY TO AVOID DELAYS IN PROCESSING

Policy Number(s)	Death Claim	Waiver of Premium Claim	Who has the Policy or Policies?
	☐	☐	
	☐	☐	

Full Name of Deceased	Residence Address of Deceased
Full Name of Insured, or owner if different from deceased	

Occupation at Death	Date Last Worked (Day / Month / Year)

Date of Death (Day / Month / Year)	Place of Death	Cause of Death
		☐ Natural ☐ Accidental Death ☐ Other
Date of Birth of the Deceased (Day / Month / Year)	**Place of Birth of the Deceased**	**Is there a birth certificate, baptismal record or other official record of this birth? ☐ Yes ☐ No If "Yes", identify:**

Complete This Section For All Deaths

1. Names and addresses of all physicians or practitioners who attended or prescribed for deceased during five years preceding death.

Names	Addresses	Date of Attendance (Day / Month / Year)	Disease or Condition

2. When did Deceased first complain of or give other indications of last illness? (Day / Month / Year)	3. When did Deceased first consult a physician for last illness? (Day / Month / Year)

4. Give full details within your knowledge regarding the cause and circumstances of death, including the name and addresses of eye witnesses. (*If additional space is needed, use the back of this form*).

_____

_____

5. Has deceased ever used tobacco products? ☐ Yes ☐ No. If "Yes" please give duration and dates: _____

6. Life, Health and Accident Insurance carried on deceased in other companies

Name of Company	Date of Policy (Day / Month / Year)	Type of Coverage ***(Life, Health or Accident)***	Amount of Life or Accident Coverage

6. a. In what capacity are you claiming? ☐ Beneficiary ☐ Executor ☐ Administrator ☐ Legal Guardian (*of Minor beneficiary*)

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

If no, to what portion are you entitled _____

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

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

PLEASE ATTACH POLICY OR POLICIES AND MEDICAL PROOF OF DEATH

CLAIMANT'S STATEMENT

1. IF THE POLICY IS PAYABLE TO A NAMED BENEFICIARY OR BENEFICIARIES

   (a) This statement should be completed by the named beneficiary, unless a minor. If there is more than one beneficiary, all should join in completing the statement or, if desired, separate forms will be supplied.

   (b) If any named beneficiary is a minor, this statement should be completed, on behalf of the minor beneficiary, by the guardian or other person authorized by law to deal with the minor's property. A Certified copy of the Letters of Guardianship must be submitted.

   (c) If any named beneficiary is deceased, proof of death of such beneficiary must be furnished.

2. IF THE POLICY IS PAYABLE TO THE ESTATE OF THE DECEASED

   (a) If the deceased left a Will this statement should be completed by the executors under the Will and a certified copy of the Letters Testamentary must be furnished.

   (b) If the deceased did not leave a Will this statement should be completed by the administrator of the estate and a certified copy of the Letters of Administration must be furnished. In jurisdictions where Letters of Administration are not granted, this form should be completed by the heirs of the deceased and proof as to who the legal heirs, are should be submitted.

3. IF THE POLICY IS ASSIGNED

   This statement should be completed by the assignee as well as the beneficiary. Payment will be made to the assignee, then to the beneficiary where applicable.

PROOF OF AGE

Formal proof of age is required unless the age has previously been admitted. A certificate of Birth or Baptism should be submitted if obtainable, otherwise any other evidence which may be available should be submitted for review by the Company.

THE POLICY

The policy is required and should be sent in to the Company.

GENERAL

1. Any local requirements regarding Succession Duties, Estate Taxes or Inheritance Taxes must be complied with before the Company may make payment of the claim.

2. All information and assistance possible in connection with furnishing proofs of claim will be given by the Company or its agents. Any expense incurred in furnishing the proofs of claim must be borne by the Claimant.

SAGICOR LIFE INC RESERVES THE RIGHT TO CALL FOR ANY ADDITIONAL PROOF DEEMED NECESSARY TO CONSIDER THE CLAIM