

Tatil Life Assurance Limited

11 Maraval Road
 Box 1004, Port of Spain
 Republic of Trinidad and Tobago



Tatil

DEATH CLAIM - STATEMENT OF CLAIMANT

1. Policy number(s) _____
2. (a) Full name of deceased _____ Date of birth _____
 (b) Residence at death _____
3. Place of death _____ Date of death _____
4. Cause of death _____
5. (a) When did the deceased first complain or give other indications of last illness? _____
 (b) When did the deceased first consult a physician for last illness? _____
 (c) On what date did the deceased last attend work as usual? _____
6. Name and address of every physician who attended to or prescribed for the deceased during the last illness and during the five years preceding death

| Name | Address | Date of Attendance or Hospitalization | Disease or Illness |
|------|---------|---------------------------------------|--------------------|
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| | | | |
| | | | |

7. (a) Are you claiming accidental death benefit? Yes No

(b) Other insurance in force (including group insurance) on the life of the deceased:

| Name of Company | Amount |
|-----------------|--------|
| | \$ |
| | \$ |
| | \$ |
| | \$ |
| | \$ |

8. (a) What is your full name? _____

(b) What is your permanent address? _____

(c) In what capacity or by what title do you make this claim?

Beneficiary Executor Administrator Assignee Other Explain _____

(d) Are you age 18 or older? Yes No If no, give date of birth _____

(e) Are you entitled to entire proceeds? Yes No If no, give amount claimed \$ _____

(f) How do you want to receive the proceeds?

Cash Deposit at interest Income for fixed period Fixed income

Life income, (If a life income is elected, proof of age is required)

9. Special Instructions

Please make cheque payable to: _____ and

deliver cheque to: _____

Name and Address

Note:- Identification must be presented by the person authorised to collect the cheque

AUTHORIZATION

I hereby certify that the above answers are full, complete and true to the best of my knowledge and I agree that in furnishing this or any claim forms for the convenience of the claimant the Company does not admit any liability or waive any of its rights.

I hereby authorise and request any physician, hospital, clinic, individual, law enforcement or government organisation or other entity that has any records or findings pertaining to the health or death of the Life Insured to furnish copies and/or give details of all available information, including prior medical history, autopsy, toxicological or pathological findings to Tatil Life Assurance Limited.

A photocopy of this authorization shall be as valid as the original.

Signed at _____

Date _____

Signature of Claimant

Witness

Signature of Claimant

Witness