TATIL LIFE ASSURANCE LIMITED
11 Maraval Road
Port of Spain
Trinidad and Tobago, W.I.

DEATH CLAIM – STATEMENT OF CLAIMANT

TATIL LIFE
Guaranteed Protection

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 last 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

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 the entire proceeds? ☐ Yes ☐ No If no, give amount claimed_____

(f) How do you want to receive the proceeds? ☐ Cheque ☐ Deposit at interest ☐ Fixed income

☐ Income for fixed period ☐ Life income, (If a life income is elected, proof of age is required)

(g) Are you a US Citizen or a lawful permanent US resident? ☐ Yes ☐ No (see KYC form for criteria)

(h) Are you a Politically Exposed Person (PEP) ☐ Yes ☐ No (see KYC form for criteria)

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9. Special instructions

Please make cheque payable to: _____

cheque to be collected at/bank to be hand delivered to: _____

Note: Identification must be presented by the person authorized 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 authorize and request any physician, hospital, clinic, individual, law enforcement or government organization 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.

Dated at _____ this _____ day of _____ 20 _____

_____ Signature of Claimant 1	_____ Signature of Witness
_____ Signature of Claimant 2	_____ Signature of Witness
_____ Signature of Claimant 3	_____ Signature of Witness

Claimant's Contact 1 #:…….……	**Claimant's 1 ID/DP/PP # :** ……..……..
Claimant's Contact 2 #:……..…….	**Claimant's 2 ID/DP/PP # :** ……..……..
Claimant's Contact 3 #:……..…….	**Claimant's 3 ID/DP/PP # :** ……...……..
Prepared By: ……	**Date: ……..…..**
Checked By: ……	**Date: ……..…….**

Certified copy of Death Certificate attached:☐	***Policy document/ Statutory Declaration attached: ☐***
Certified copy of Claimant(s) ID/DP/PP attached: ☐	***Certified copy of deceased ID/DP/PP attached: ☐***
Certified copy of Marriage Certificate attached (if applicable): ☐	***Certified copy of Proof of Address of the Claimant: ☐***
Certified copy of Probate of Will/Letters of Administration attached (if applicable): ☐	***Deduction Cancellation order attached: ☐***