

CLAIM NO. _____

PROOFS OF DEATH

CLAIMANT'S STATEMENT

Numbers of Policies in this Society

Sums Assured

Life Assured's Full Name

If A Married Woman, State Maiden Name

Age

Residence At Death? _____

Occupation At Death? _____

Date & Place of Deceased's Birth? _____

Source from which Date of Birth Obtained? _____

Date & Place of Death? _____

Cause of Death? _____

When did the Deceased first complain of or give other Indications of his last Illness? _____

When did the Deceased first consult a Physician for his last illness? _____

On what Date did the Deceased last attend to his usual work? _____

Name & Address of all Physicians who attended the Deceased during his last illness and during three years prior thereto?

NAME

ADDRESS

DATE of ATTENDANCE

DISEASE/CONDITION

Had the Deceased within the last three years been an inmate of, or under treatment at a hospital Sanitarium, Asylum or other Institution? if so, state when, where and for what cause: -

In what other Companies and for what amounts was the Life of the Deceased insured?

COMPANIES

POLICY NUMBERS

POLICY DATED

AMOUNTS of INSURANCE

In what capacity or by what title do you claim this insurance? If Assignee, see instructions on next page:

Who has possession of the Policy? _____

Do you elect one of the Optional Modes of Settlement in lieu of an Immediate Cash Payment? _____

If so, which Mode of Settlement? _____

What is your Date of Birth? _____

THE UNDERSIGNED HEREBY MAKES CLAIM TO SAID INSURANCE AND AGREES THAT THE WRITTEN STATEMENTS AND AFFIDAVITS OF ALL THE PHYSICIANS WHO ATTENDED OR TREATED THE LIFE ASSURED AND ALL OTHER PAPERS CALLED FOR BY THE INSTRUCTIONS HEREON SHALL CONSTITUTE AND ARE HEREBY MADE PART OF THESE PROOFS OF DEATH AND FURTHER AGREES THAT THE FURNISHING OF THIS FORM OR OF ANY OTHER FORMS SUPPLEMENTAL THERETO, BY THE SOCIETY SHALL NOT CONSTITUTE NOR BE CONSIDERED ADMISSION AS TO THE EFFECT OF ANY INSURANCE POLICY OR LIABILITY THEREUNDER ON THE LIFE IN QUESTION, NOR A WAIVER OF ANY OF THE SOCIETY'S RIGHTS OR DEFENCES.

Print Name: - _____

DATED THIS _____ DAY OF _____ 20 _____

SIGNATURE: _____

ON THIS _____ DAY OF _____ 20 _____

ADDRESS: _____

PERSONALLY APPEARED BEFORE ME ABOVE NAMED
WHO IS KNOWN TO ME AND WHO SUBSCRIBED THE FOREGOING STATEMENT
BEFORE ME AND MADE OATH THAT THE FOREGOING ANSWERS ARE EACH AND ALL COMPLETE AND TRUE.

INSTRUCTIONS

In ordinary cases, proofs of death required are as follows:

STATEMENT CL-1 must be made by the person or persons from whom a valid legal discharge can be accepted. This Statement must be sworn to before an Officer authorised by law to administer oaths.

When a policy is payable to the executor or administrator of the insured, the statement must be made by an executor or administrator, a certificate of whose appointment and qualification must be furnished.

When a policy is payable under an assignment, the statement must be made by the assignee. The original assignment must be produced.

When an official inquiry as to the cause of death has been made, a copy of the verdict or findings, duly certified must be furnished with this statement.

STATEMENT CL-2 must be made by every physician who attended the deceased during his last illness and for this purpose the Society will furnish as many Statement Forms as are required.

STATEMENT CL-3 must be executed by a person of legal age, closely acquainted with, but not related to the deceased, who has seen the remains and has no interest in the policy proceeds. This Statement must be sworn to before an Officer authorised by law to administer oaths. every question must be distinctly and fully answered.

The Society reserves the right to require or obtain further information should it be deemed necessary. The Policy, unless already in the Society's possession, together with evidence of the date of birth of the Life Assured (unless age has previously admitted) should accompany the proof forms.

The fees and expenses, if any, arising from the submission of the required proofs are payable by the claimant.