CG | ATLANTIC
MEDICAL & LIFE

PROOF OF DEATH:
CLAIMANT STATEMENT

Life Choices

In furnishing this or other claims forms for the convenience of the claimant, the Company does not admit any liability or waive any of its rights.

PART 1 POLICY DETAILS

Policy Numbers for which a claim is being made: _____

PART 2 INSURED DETAILS

Deceased's Name (in full): _____ Date of Death (DD/MM/YY): _____

Cause of Death: _____

Date and Place of Birth (DD/MM/YY): _____

Names and Addresses of all physicians who attended the deceased in the past 5 years:

Name	Address	Date of Visit	Reason for Visit

Names and locations of all hospitals or institutions where the deceased was treated in the past 5 years:

Hospital or Institution	City	Date of Treatment

Was the deceased the Owner of any other policies with this company insuring the lives of relatives/other persons?

☐ Yes ☐ No If Yes, please list the numbers? _____

PART 3 CLAIMANT DETAILS

To be completed for each beneficiary/payee and remitted with a colour copy of government ID and proof of residence.

Claimant's Name: _____ Date of Birth (DD/MM/YY): _____

Relationship to the deceased: _____

Claimant's Residential Address: _____ (Mailing address not acceptable)

Claimant's Phone Number: _____ NIB Number: _____

Claimant's Place of Birth: _____ Claimant's Citizenship*: _____

*For US Citizens - Tax ID Number _____ Claimant's Occupation: _____

Employment Status: _____ Employer Name: _____

If self-employed, please provide details and nature of business: _____

The term "Politically Exposed Person" applies to someone who currently has, or has had, a position of public trust (e.g., government official, senior executive of government corporations, politician, important political party official, etc.) or an individual who is closely related to/associated with such a person. Does this description apply to you? ☐ Yes ☐ No

I certify that the information provided is accurate and complete.

Claimant's Signature: _____ Date: _____

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PART 4 CLAIMANT DETAILS

To be completed for each beneficiary/payee and remitted with a colour copy of government ID and proof of residence.

Claimant's Name: _____ Date of Birth (DD/MM/YY): _____

Relationship to the deceased: _____

Claimant's Residential Address: _____ (Mailing address not acceptable)

Claimant's Phone Number: _____ NIB Number: _____

Claimant's Place of Birth: _____ Claimant's Citizenship*: _____

*For US Citizens - Tax ID Number _____ Claimant's Occupation: _____

Employment Status: _____ Employer Name: _____

If self-employed, please provide details and nature of business: _____

The term "Politically Exposed Person" applies to someone who currently has, or has had, a position of public trust (e.g., government official, senior executive of government corporations, politician, important political party official, etc.) or an individual who is closely related to/associated with such a person. Does this description apply to you? ☐ Yes ☐ No

If Yes, please explain: _____

I certify that the information provided is accurate and complete.

Claimant's Signature: _____ Date: _____

PART 5 AUTHORIZATION

I authorize all physicians and other persons who have attended the deceased and all hospitals, institutions and government authorities to furnish to CG Atlantic Medical & Life Insurance Ltd., all information in their possession or within their knowledge respecting the deceased and to honour a photo static copy of this authorization.

Signed at _____ this _____ day of _____, 20 _____ .

Signature of Claimant: _____

Witness: _____