28-48 Barbados Avenue, Kingston 5 Telephone 929-8920-9 Fax # 929-4730

GROUP DEATH BENEFIT NOTICE OF CLAIM FORM

NOTE: DOCUMENTS TO BE SUBMITTED ALONG WITH CLAIM ARE LISTED BELOW.

POLICYHOLDER'S STATEMENT (FOR ALL POLICIES)

GROUP POLICY #	NAME OF COMPANY / SCHOOL:	CERTIFICATE #	COVERAGE AMOUNT

NAME OF DECEASED	LAST ADDRESS

DATE OF DEATH DAY MTH. YEAR	DATE OF BIRTH	CAUSE OF DEATH	WAS DEATH A RESULT OF AN ACCIDENT? ☐ YES ☐ NO

OCCUPATION AT TIME OF DEATH (if applicable)	LAST FULL DAY WORKED (if applicable)	ANNUAL SALARY (if applicable)	EFFECTIVE DATE OF INSURANCE DAY MONTH YEAR

CLAIMANT'S INFORMATION

NAME (S) OF CLAIMANT (S)	ADDRESS OF CLAIMANT	
RELATIONSHIP OF CLAIMANT TO DECEASED (State if Beneficiary, Trustee, Executor etc.)	HAVE ALL PERSONS ATTAINED THE AGE OF 18 YRS? ☐ YES ☐ NO	IF NO: STATE DATE(S) OF BIRTH

EMPLOYER'S INFORMATION

NAME OF POLICYHOLDER: (COMPANY / ORGANIZATION)	DATED AT________________
NAME & SIGNATURE OF AUTHORIZED PERSON ________________	THIS________DAY OF________
TITLE OR POSITION (Please affix company Stamp)	20________

ITEMS REQUIRED (TICK IF ATTACHED)

☐ PHYSICIAN'S STATEMENT OR DEATH CERTIFICATE	☐ CORONER'S INQUEST REPORT
☐ CERTIFIED COPY OF LETTERS OF PROBATE OR LETTERS OF ADMINISTRATION	☐ POLICE REPORT
	☐ POST MORTEM REPORT

THE COMPANY RESERVES THE RIGHT TO REQUEST ADDITIONAL INFORMATION IF DEEMED NECESSARY

Sagicor

28 - 48 Barbados Avenue, Kingston 5, P.O. Box 439, Kingston Jamaica, WI Phone : (809) 929 - 8920 - 9, Fax No. (809) 929 - 4730

PROOF OF DEATH - PHYSICIAN'S STATEMENT

NOTE : The medical certification follows the recommendations of the World Health Assembly made in Geneva and has been accepted in Canada and the United States.

In the interest of accurate vital statistics, please conform to the International List of the Causes of Death.

1. (a) Full name of Deceased ____________________

Residence at death ____________________

____

Age at death ____________________

(b) Date of Death ____________________

Place of Death ____________________

If Institution or Hospital, give name ______

____

		Interval between onset and death
2	CAUSE OF DEATH (enter only one cause for each of a, b and c).	
(a)	Discase or condition directly leading to death: (This does not mean the mode of dying to death : (This does not mean the mode of dying such as heart failure, asthenia, etc. It means the discease, injury or complication which caused death).	(a)
	Antecedent causes. (Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last).	
(b)	Due to	(b)
(c)	Due to	(c)
(d)	Was death due directly or indirectly to acquired Immune Deficiency Syndrome (A.I.D.S) or A.I.D.S related complex (ARC)? Yes [ ] No [ ] If so, when was the condition first diagnosed?	
	Other significant condition: (contributing to the death but not related to the disease or condition causing death).	

3. (a) Date of first attendance in last ____________________

(b) Date of last attendance in the last ____________________

(SEE OVER)

4. (a) If death was due to accident, suicide or homicide, specify which.

(b) If due to suicide, did the deceased to your knowledge have AIDS or ARC at the time of death.

Yes [ ] No [ ]

(c) Was an inquest held? Yes [ ] No [ ]

Was an autopsy performed? Yes [ ] No [ ]

If so, by when and with what findings?
(Please attach copies of report if available).

5 Have you treated or advised the deceased during the last five years, prior to last illness?
Yes [ ] No [ ]

Did the deceased, to your knowledge, receive treatment during the five years from any other physician, or in any hospital or institution? Yes [ ] No [ ]

If yes to aither question, please furnish the following:

Name	Address	Nature of illness or Injury	Approximate Dates
....	....	....	....
....	....	....	....

Space is available below for elaboration.

____________________ M.D.
Please Print

____________________ M.D.
Signature

____________________ 20 ______
Date

____
Address