Sagicor Life

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