

Life Choices

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(S) DETAILS

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

Claimant 1 Name: _____ **Date of Birth (DD/MM/YY):** _____

Relationship to the deceased: _____

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

Please make the cheque payable to: _____

Contact Number when ready for collection: _____

Please deposit to the following Bank/Account No.: _____

I certify that the information provided is accurate and complete.

Claimant 1 Signature: _____ Date: _____

Claimant 2 Name: _____ **Date of Birth (DD/MM/YY):** _____

Relationship to the deceased: _____

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

Please make the cheque payable to: _____

Contact Number when ready for collection: _____

Please deposit to the following Bank/Account No.: _____

I certify that the information provided is accurate and complete.

Claimant 2 Signature: _____ Date: _____

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PART 4 AUTHORISATION

I authorise all physicians and other persons who have attended the deceased and all hospitals, institutions and government authorities to furnish to Coralisle Life Assurance Company Ltd., all information in their possession or within their knowledge respecting the deceased and to honour a photo static copy of this authorisation.

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

Signature of Claimant: _____

Witness: _____

NOTE: 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.