COLONIAL LIFE
INSURANCE COMPANY (TRINIDAD) LIMITED

Claim for Death Benefit

Head Office: 29 St Vincent Street, Port of Spain, Republic of Trinidad and Tobago, W.I. Tel: (868)– 623-1421 Fax: (868)- 627-3821
Email: info@clico.com Website: clico.com

Individual ☐ Group ☐ **Ref No _____**

It is hereby admitted and agreed that this Certificate of Dr. _____ shall be considered as part of the Proof of Death under Policy No._____ in accordance with the conditions of said Policy.

Physician's Statement

The Physician will greatly aid the claimant in securing prompt action on the claim by giving the following questions full and complete answers in accordance with the instructions given below.

1. **Insured:** First Name _____ Middle Name _____ Last Name _____

2. **Address:** _____
No. street city country

3. **Date of Birth:** ____/____/____ (day month year) **Date of Death:** ____/____/____ (day month year) **Sex: Male ☐ Female ☐ Apparent Age:** ____

4. **Place of death. If death occurred in a Hospital or Institution, give name.**
_____

5 a. **Cause of death:** _____

b. **Contributed by, secondary to, or complicated with:** _____

Duration from personal knowledge: Years _____ **Months** _____ **Days** _____

Duration from history given: Years _____ **Months** _____ **Days** _____

6. **Date of first visit in last illness?** ____/____/____ (day month year)

7. **How long has deceased been ill when you were called to attend in that illness?** _____

8. **Was deceased afflicted with infirmity, deformity or chronic disease?** _____

If so, please specify: _____

9. **Was there an inquest or Post Mortem examination? YES ☐ NO ☐**

10. **Please state the diseases for which you attended deceased and date of attendance other than that asked in Questions 5, 6, and 7.**

From: ____/____/____ (day month year) **To:** ____/____/____ (day month year) **For:** _____ **Duration:** _____

From: ____/____/____ (day month year) **To:** ____/____/____ (day month year) **For:** _____ **Duration:** _____

I hereby certify that the answers as above recorded are complete and true to the best of my knowledge and belief.

Signature of Physician _____ **Date** _____

NOTE: Claimants are bound to produce, at their own expense, such medical testimony as to cause of death, duration of disease, etc., as may be required by Colonial Life Insurance Company (Trinidad) Limited. If an inquest is to be held, the Coroner's certificate and a copy of the evidence must be produced when requested.

Undertaker's Certificate

I _____ **do certify that I am an Undertaker, residing at** _____ **and as such Undertaker, I attended the funeral of** _____ **and he/she was interred in** _____ **on the** _____ **day of** _____ **at** _____

Signed _____

Claimant's Statement

1. **Deceased's Name:**

First Name **Middle Name**

Last Name

2. **Occupation at date of death:** _____

3. a. **Date of Deceased's last day of work:** _____/_____/_____ (day / month / year)

4. **Names and addresses of all physicians who attended deceased during his/her last illness and during the three years prior thereto:**

Names	Addresses	Date of Attendance	Diseases

5. **In what other companies and for what amounts was the life of the Deceased insured?**

Association or Company	Policies Dated	Amount of Insurance

6. a. **What is your relationship to the Deceased?** _____

b. **In what capacity, or by what title, do you claim this insurance?** _____

7. **Who has possession of the policy?** _____

The undersigned hereby makes claim to said insurance in Colonial Life Insurance Company (Trinidad) Limited, and agrees that the written statements and affidavits of all physicians who attended or treated the Insured, and all other papers called for by the instructions hereon shall constitute and they are hereby made a part of these Proofs of Death, and further agrees that the furnishing of this form, or of any other forms supplemental thereto, by said Company shall not constitute nor be considered on admission by it that there was any insurance in force on the life in question, nor waiver of any of its rights or defenses.

Dated at _____ **this** _____ **day of** _____

in the year _____

Signature: _____ **Age:** _____

Address: _____

No. street city country

Signature: _____ **Age:** _____

Address: _____

No. street city country

On this _____ **day of** _____ **in the year** _____ **personally appeared before me the 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.**

(OFFICIAL SEAL)

Employer's Statement

(For group plans only)

1. a. **Name of employer:** _____ b. **Group Policy No.:** _____

c. **Membership certificate no.:** _____ d. **Amount of Insurance:** _____

2. a **Name of deceased in full:** _____ b. **Date of Death:** _____/_____/_____ (day / month / year)

c. **Date last actively at work:** _____

3. **If the employer/employee relationship was terminated before death, give date and reason:**

Date: _____/_____/_____ (day / month / year) **Reason:** _____

4. a. **Name of beneficiary:** _____ b. **Age of Beneficiary:** _____

c. **Relationship to deceased:** _____ d. **Title:** _____

Date: _____/_____/_____ (day / month / year) _____ **Signature of Employer's Authorised Representative** _____ **Title**