CAYMAN FIRST
FIRST IN INSURANCE. TODAY. TOMORROW.

Group Death Claim

Form No. GIS018 Aug 10, 2010

PLEASE PRINT **Part 1**

POLICYOWNER'S STATEMENT

Policy No: _____ Certificate No: _____ Insured Sum: _____

Name of Deceased: _____ Last address: _____

Date of Birth: _____ (DD/MM/YY) Date of Death: _____ (DD/MM/YY) Age at death: _____

Occupation at death: _____ Last fulltime day worked: _____ (DD/MM/YY)

Effective date of Deceased's Insurance: _____ (DD/MM/YY) Annual salary at time of death: CI$ _____

CLAIMANT(S)

Claimant(s): _____

Address(es) of Claimant(s): _____
P O Box Town/City Country Postal Code

Relationship(s) to Deceased: _____

Are claimants at least 18 years old? [ ] Yes [ ] No If no, please state dates of birth: _____

_____ _____
Signature(s) of Claimant(s) Date

CERTIFICATION

On behalf of the Policyowner, I confirm that the foregoing statements are true and correct as verified by our records.

Authorised Policyowner Representative

_____
Date Name (Please Print) Title Signature

DOCUMENTS TO BE SUBMITTED WITH THIS COMPLETED CLAIM FORM

Please tick if attached:

[ ] Proof of Death - Physician's Statement or certified death certificate

[ ] Claimant's ID's - picture ID, proof of age and proof of relationship

[ ] Certified copies of Letters of Probate or Administration, if necessary

[ ] Coroner's Inquest Report

[ ] Post Mortem Report

[ ] Police Report, if accidental death

The company reserves the right to request additional evidence of death should it be deemed necessary.

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Part 2

PROOF OF DEATH - PHYSICIAN'S STATEMENT

The Medical certification follows the recommendations of the World Health Assembly made in Geneva on July 24, 1948.
In the interest of accurate vital statistics, please conform to the International List of the Causes of Death.

Full name of deceased:	Date of death:
Residence at death:	Place of death:
Age at death or date of birth:	If institution or hospital, give name:

Cause of death *(enter only one cause for each of a, b and c.)*	Interval between onset and death
Disease or condition directly leading to death: *(This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)* (a)	(a)
Antecedent causes. *(Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.)* Due to (b)	(b)
Due to (c)	(c)
Other significant conditions: *(contributing to the death but not related to the disease or condition causing death).*	

Date of first attendance in last illness	Date of last attendance in last illness
If death was due to accident, suicide or homicide, specify which. Describe briefly.	Was inquest held? [ ] Yes [ ] No Was autopsy performed? [ ] Yes [ ] No If so, by whom and with what findings?

Have you treated or advised the deceased during the last five years, prior to the last illness? [ ] Yes [ ] No
Did the deceased, to your knowledge, receive treatment during the last five years from any other physician, or in any hospital or institution? [ ] Yes [ ] No

If Yes to either question, please furnish the following:

Name	Address	Nature of Illness or Injury	Approximate Dates

(Print or stamp)

Physician's Name: _____

Address: _____

_____

_____ Date

_____ Signature