FAMILY GUARDIAN
INSURANCE COMPANY

Death Claim Forms

Accompanying Instruction Sheet

For Death Claims, the following documentation is required to be submitted to the Family Guardian at fgclaims@familyguardian.com:

- Original/Certified copy of the death certificate
- Completed Claimant's Statement and Physician Statement (See attached)
- Copy of the Insured's ID (valid passport, voter's card or driver's license)
- Copy of Beneficiary's ID (valid passport, voter's card or driver's license)
- Payment authorization form if proceeds to be paid to third party

FAMILY GUARDIAN
INSURANCE COMPANY LIMITED

DEATH — Claimant's Statement

Policy Number(s):

Full Name of Deceased:

Date of Birth: MM DD YY **Place of Birth:**

From what Record was D.O.B. attained:

Date of Death: MM DD YY **Place of Death:**

Cause of Death:

When did health of deceased first become impaired?

In last illness, when did deceased first consult physician?

On what date did deceased last attend to usual work?

TOBACCO USE: **Did the deceased smoke?** ☐ Yes ☐ No

If not, did he/she ever smoke? ☐ Yes ☐ No **If yes when did he/she quit**

Have you reached the age of majority? ☐ Yes ☐ No

In what capacity or by what title do you claim this insurance?

(Beneficiary, Executor, Administrator, etc.)

BENEFICIARY #1:

Are you entitled to the entire proceeds of this insurance? ☐ Yes ☐ No

Telephone No(s): **P.O. Box:**

BENEFICIARY #2:

Are you entitled to the entire proceeds of this insurance? ☐ Yes ☐ No

Telephone No(s): **P.O. Box:**

List all physicians who attended or prescribed for the deceased within the last 5 years preceding death.

Name	Address	Dates of Attendance	Disease

List all other life and accident insurance on the life of the deceased.

Company	Issue Date	Face Amount of Insurance
		$
		$
		$
		$

THE FAMILY GUARDIAN INSURANCE COMPANY, LTD.

The undersigned hereby makes claim to said insurance and understands that the furnishing of forms by the Company does not constitute an admission that there is any insurance in force. The undersigned agrees to indemnify and hold harmless the above named Company from any and all costs, actions, losses, or damages, which it may suffer by virtue of payment of any proceeds under the above described policies and agrees to join into any litigation concerning the payment of said proceeds and furnish further proofs, if requested.

Signed this day of , 20

1. **Witness** **Signature**

2. **Witness** **Signature**

FAMILY GUARDIAN
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INSTRUCTIONS

1. This Claimant's Statement must be completed and signed by all beneficiaries and assignees.
2. Attached a certified copy of the death certificate and all policies.
3. If any beneficiary is a minor, we required certified letters of guardianship or a letter authorizing us to hold the proceeds at interest until the minor attains legal age.
4. If the Estate is the beneficiary, enclose Letters of Administration or Probate of Will.
5. You must complete AUTHORIZATION TO OBTAIN INFORMATION below.

AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any health care professional, hospital, public or private health or social services establishment, or other medical or medically related facility, any insurance company, insurance broker or broker, or its affiliate, the Medical Information Bureau, any financial institution, other organizations, institutions, police department, or person that has any records or knowledge of the Insured to provide to and exchange with Family Guardian Insurance Company Ltd. all such information and records.

I UNDERSTAND the information obtained by use of the Authorization will be used by Family Guardian Insurance Company, Ltd., Nassau, to determine eligibility for benefits under an existing policy. Any information obtained will not be released by Family Guardian Insurance Company, Ltd., Nassau, to any person or organization EXCEPT to reinsuring companies, or other person or organization performing business or legal services in connection with my claim, or may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid during the tendency of this claim.

Policy Number(s): _____ **(x)** _____ _____

Signature **Date**

Policy Number(s): _____ **(x)** _____ _____

Signature **Date**

☐ Spouse/Representative of Deceased
☐ Surviving Joint Insured
☐ Parent/Guardian of Minor Child/Children

Insured(s): _____

Name(s): _____

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Please answer all questions.

DEATH PROOF OF CLAIM Physician's Statement

Note: The Medical certification follows the recommendations of the World Health Assembly made in Geneva, Switzerland on July 24, 1948. It has been accepted by all States in the U.S.A. and in Canada. In the interest of accurate vital statistics, please conform to the International List of the Cause of Death.

Full Name of Deceased:		**Date of Death:**	MM	DD	YY
Residence at Death:		**Place of Death:**			
Age at Death / Date of Birth:		**Name of Hospital/Institution:**			
TOBACCO USE: Did the deceased smoke?	☐ Yes ☐ No				
If not, did he/she ever smoke?	☐ Yes ☐ No	**If yes, when did he/she quit?**			

CAUSE OF DEATH: *(Enter only one cause for each a, b and c)*

Interval Between Onset & 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.)

	MM	DD	YY		MM	DD	YY
Date of First Attendance in Last Illness:				**Date of Last Attendance in Last Illness:**			

Specify whether death was due to accident, suicide, homicide, or natural causes. *Describe briefly.*

Was an inquest held? ☐ Yes ☐ No **Was an autopsy performed?** ☐ Yes ☐ No

If YES, by whom and with what findings?

Have you treated or advised the deceased during the last 5 years prior to last illness? ☐ Yes ☐ No

Did the deceased, to your knowledge, receive treatment during the last 5 years from any other physician or in any Hospital or Institution? ☐ Yes ☐ No

If YES to either question, please complete the following:

Name	Address	Nature of Illness/Injury	Dates

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature **M.D.** **Date**

Address:

City: **Country:**

FAMILY GUARDIAN
INSURANCE COMPANY LIMITED

PAYMENT AUTHORIZATION

INSURED DETAILS:

Full Name:

Policy Number(s):

Address:

Amount of Insurance:

BENEFICIARY/PREMIUM PAYOR DETAILS #1:

Full Name:

Address:

Phone: Home Cell Work

BENEFICIARY/PREMIUM PAYOR DETAILS #2:

Full Name:

Address:

Phone: Home Cell Work

KNOW ALL PERSONS BY THESE PRESENTS: That the undersigned, both personally and in any representative capacity, authorizes Family Guardian Insurance Company Limited to pay to:

Full Name:

Address:

Sum of:

And do hereby, on behalf of ourselves, our heirs, executors, administrators and assigns, release and forever discharge the said company, its successors and assigns, from any and all claims, demands, actions, causes of action, suits at law or in equity, of whatsoever kind of nature with reference to the released amount and do hereby surrender the heretofore mentioned policy to the said company for cancellation.

The undersigned acknowledges that no representations or statements have been made to the undersigned by the company; and that the undersigned has read this authorization release and fully understands the conditions under which it is made; and the undersigned further represents that the undersigned is of lawful age and legally competent to execute the same.

Dated at: **this** **day of** **, 20**

X Witness

X Insured/Beneficiary/Claimant (Seal)

X Witness

X Insured/Beneficiary/Claimant (Seal)

X

X (Seal)