COLINA

Colina Insurance Limited
P.O. Box N 4728
Nassau, The Bahamas

CLAIMANT'S STATEMENT (PROOF OF DEATH)

The Claimant's Statement must be completed by the person or persons making claim to a Life Insurance Death Benefit and accompanied by a **Certified Death Certificate**. If the Claimant is a beneficiary, each beneficiary must complete his or her own Claimant's Statement. To expedite this process, **please provide all required information about yourself and the Life Insured. We cannot settle this claim unless all questions are answered completely.**

Policy Number	Sum Insured
	$
	$
	$

Policy Number	Sum Insured
	$
	$
	$

A. INFORMATION ABOUT THE LIFE INSURED

Life Insured's Full Name
First Name | Middle Initial | Last Name

Place of Birth

Date of Birth DD / MM / YYYY

Source from which date of birth was obtained i.e. Birth or Baptismal Certificate / Passport

Place of Death

Date of Death DD / MM / YYYY

Cause of Death

Occupation of the Life Insured

When was the Life Insured's health first affected? (if applicable)

When was the Life Insured's last official work day? (if applicable)

If death resulted solely from bodily injuries, state whether death was due to accident, suicide, or homicide

Address of Life Insured
No. / Street | City | State / Province / Island | P.O. Box / Postal Code

Did the Life Insured ever use any product containing tobacco?
☐ Yes ☐ No

When did the Life Insured start smoking? DD / MM / YYYY

When did the Life Insured stop smoking? DD / MM / YYYY

Name & Address of each attending physician for the Life Insured during the last five (5) years prior to death

B. CLAIMANT'S INFORMATION

Legal Name of Claimant ☐Mr. ☐Mrs. ☐Miss ☐Ms.
First Name | Middle Name | Last Name | Maiden Name

Date of Birth DD / MM / YYYY

Age (last birthday)

Legal Name of Life Policyowner (if other than the Life Insured) ☐Mr. ☐Mrs. ☐Miss ☐Ms.
First Name | Middle Name | Last Name | Maiden Name

Date of Birth DD / MM / YYYY

Age (last birthday)

Place of Birth
If other than The Bahamas, provide Immigration Status

Marital Status

National Ins. No.

Sex
☐ Male ☐ Female

Social Security. No.

Tax Identification No.

Nationality	Passports Held	Passport Number	Expiry Date DD / MM / YYYY	Country of Residence	Country of Permanent Residence
☐ Bahamas	☐ Bahamas		/ /	☐ Bahamas	☐ Bahamas
☐ US	☐ US		/ /	☐ US	☐ US
☐ UK	☐ UK		/ /	☐ UK	☐ UK
☐ Canada	☐ Canada		/ /	☐ Canada	☐ Canada
Other			/ /	Other	

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CLAIMANT'S STATEMENT (PROOF OF DEATH)

Local Telephone Numbers

Residence	Business	Cell	Fax

E-Mail Address

Local Residence

No. / Street	City	State / Province / Island	P.O. Box

No. of Years Residing There

Foreign Telephone Numbers (if applicable)

Residence	Business	Cell	Fax

Foreign Residence (if applicable)

No. / Street	City	State / Province / Island	Zip Code

No. of Years Residing There

Previous Residence (if living at present address less than five years)

No. / Street	City	State / Province / Island	P.O. Box

No. of Years Residing There

Relationship to the Life Insured, i.e. husband, wife, child, parent, etc.

In what capacity do you make this claim? ☐ Beneficiary ☐ Assignee ☐ Executor ☐ Administrator ☐ Guardian ☐ Trustee

Name of person in possession of this policy contract

Is an Administrator or Executor to be appointed?

C. AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any hospital, physician or other person who examined or attended to:

to furnish to Colina Insurance Limited, or a representative thereof, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

The information given is to the best of my knowledge, true and accurate.

Name of Claimant

Date

DD	MM	YYYY

Claimant's Signature