COLINA

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

CLAIMANT'S STATEMENT (PROOF OF DEATH)

PHYSICIAN'S CERTIFICATE

Note: To be furnished without expense to the Company.
Please sign and stamp for certification

Life Insured's Full Name

First Name | Middle Initial | Last Name

Employer

Age at Death

Date of Death (DD / MM / YYYY)

Residence at death

No. / Street | City | State / Province / Island | P.O. Box / Postal Code

Cause of Death (enter only one cause for each)	**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).	
Antecedent causes (morbid conditions, if any, giving rise to the above condition due to or as a consequence of (a) (b) (c)	
Other significant conditions (contributing to the death but not related to the disease or condition causing death).	

As it pertains to the illness(es) that led to death;

(a) What was the date of the first visit by the Life Insured? DD / MM / YYYY

(b) What was the date of the last visit by the Life Insured? DD / MM / YYYY

Was death related to acquired immune deficiency syndrome? ☐ Yes ☐ No

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

Did the Life Insured receive treatment during the last 5 years from any other physician? ☐ Yes ☐ No

If 'Yes', please provide the following:

Name of Physician | Address | Date of Diagnosis (DD / MM / YYYY)

When was the Life Insured initially advised of this illness? DD / MM / YYYY

Name of Physician | Signature of Physician | Date (DD / MM / YYYY)

Medical / File No.

Physician's Stamp

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CLAIMANT'S STATEMENT (PROOF OF DEATH)

EMPLOYER'S CERTIFICATE

(to be completed only if the claim is for group life insurance)

Please sign and stamp for certification

This is to certify that the facts as indicated below are true to the best of my knowledge and belief.

Life Insured's Full Name			Date of Birth			Date of Death		
First Name	Middle Initial	Last Name	DD	MM	YYYY	DD	MM	YYYY

Policy No.	Certificate No.	Amount of Insurance	Date of last increase in benefits

Residence at death	Was the above considered an employee until date of death

Date Employed	Date of last active service	Class	Occupation

Life Insured's Relationship to Beneficiary

Is the Life Insured the ☐ Insured or ☐ Dependent

If Life Insured is a Dependent please provide name

Name of Beneficiary

Is the Beneficiary of legal age? ☐ Yes ☐ No

Address of Beneficiary

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

Declaration - I certify that the information given is complete and true.

Date Signed			Authorized Signature	Name of Employer	Title
DD	MM	YYYY			

This issuance of this form does not necessarily indicate the existence of any policy being issued, nor does it recognize the validity of any claim, and is without prejudice to the Company's legal rights in the premises.

Employer's Stamp