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 complete all information about yourself and the Life Insured. We cannont settle this claim unless all question 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?

When did the Life Insured give up all work? | If death resulted solely from bodily injuries, state whether death was due to accident, suicide, homicide

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

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	

Local Telephone Numbers (Residence / Business / Cell / Fax) | E-Mail Address

Local Residence Address (No. / Street | City | State / Province / Island | P.O. Box) | No. of Years Residing There

Foreign Telephone Numbers

Residence	Business	Cell	Fax

Foreign Residence Address

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

No. of Years Residing There

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

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

No. of Years Residing There

Did the Life Insured ever use tobacco under any form?
◯ Yes ◯ No

When did the Life Insured start smoking?

DD	MM	YYYY

When did the Life Insured stop smoking?

DD	MM	YYYY

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 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