

CLAIMANT'S STATEMENT

1.	Deceased's Name	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">First Name</td> <td style="width: 50%; text-align: center;">Middle Name</td> </tr> <tr> <td style="width: 50%; text-align: center;">Last Name</td> <td style="width: 50%;"></td> </tr> </table>	First Name	Middle Name	Last Name									
First Name	Middle Name													
Last Name														
2.	Occupation at date of death?	_____												
3. (a)	Date of Deceased last day of work:	____/____/____ <small>month / day / year</small>												
4.	Names and addresses of all physicians who attended deceased during his/her last illness and during the three years prior thereto:													
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Names</th> <th style="width: 30%;">Addresses</th> <th style="width: 20%;">Date of Attendance</th> <th style="width: 20%;">Diseases</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>		Names	Addresses	Date of Attendance	Diseases								
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5.	In what other Companies and for what amounts was the Life of the Deceased insured?													
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%;">Association or Company</th> <th style="width: 35%;">Policies Dated</th> <th style="width: 30%;">Amount of Insurance</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>		Association or Company	Policies Dated	Amount of Insurance									
Association or Company	Policies Dated	Amount of Insurance												
6. (a)	What is your relationship to the Deceased? _____													
(b)	In what capacity, or by what title, do you claim this insurance? _____													
7.	Who has possession of the policy? _____													
<p>The undersigned hereby makes claim to said insurance in the Colonial Life Insurance Company [Trinidad] Limited, and agrees that the written statements and affidavits of all physicians who attended or treated the insured, and all other papers called for by the instructions hereon shall constitute and they are hereby made a part of these Proofs of Death, and further agrees that the furnishing of this form, or of any other forms supplemental thereto, by said Company shall not constitute nor be considered on admission by it that there was any insurance in force on the life in question, nor waiver of any of its rights or defenses.</p> <p>Dated at _____ this - _____ day of _____ in the year _____</p> <p>Signature _____ Age _____</p> <p>Address: _____ <small>No. street city country</small></p> <p>Signature _____ Age _____</p> <p>Address: _____ <small>No. street city country</small></p>														
<p>On this _____ day of _____ in the year _____ personally appeared before me the above named _____ who is known to me and who subscribed the foregoing statement before me and made oath that the foregoing answers are each and all complete and true.</p> <p style="text-align: left; margin-top: 20px;">(OFFICIAL SEAL)</p>														

EMPLOYER'S STATEMENT

(For group plans only)

1. (a) Name of employer _____	(b) Group Policy No. _____
(c) Membership certificate no. _____	(d) Amount of Insurance _____
2. (a) Name of deceased in full _____	(b) Date of Death _____
(c) Date last actively at work ____/____/____ <small>month / day / year</small>	
3. If the employer - employee relationship was terminated before death, give date and reason:	
Date ____/____/____ Reason: _____ <small>month / day / year</small>	
4. (a) Name of beneficiary: _____	(b) Age of Beneficiary _____
(c) Relationship to deceased _____	(d) Title _____
DATE ____/____/____ <small>month / day / year</small>	_____
Signature of Employer's Authorized Representative	Title