NAGICO INSURANCES

PROOF OF DEATH CLAIM- GROUP INSURANCE

SECTION 1 — EMPLOYER'S STATEMENT

1. Name of the deceased employee:	
2. Residence of the deceased:	
3. Master Policy No.:	
4. Amount of Insurance:	
5. Date employee last worked full time (YYY/MM/DD):	

6. Reason for termination of active, full time employment:

- ☐ Sickness or injury (describe): _____
- ☐ Granted leave of absence from: _____ to: _____
- ☐ Temporarily laid off from: _____
- ☐ Other (specify): _____

7. Due date of last premium paid with respect to the insurance of the deceased employee:	
8. If death was caused by accident was such accident associated with his occupation?	

Employer: _____ (Affix Company stamp)

_____ (Signature of company official)

Date: _____

Title: _____

SECTION 2 — CLAIMANT'S STATEMENT

1. Name of the claimant (please print);			
2. Name of the deceased			
3. Date and place of birth of the deceased	Date:	Place:	Proof:
4. Cause of death			
5. In what capacity do you claim the death benefit- as beneficiary, as executor or as administrator?	(If Claiming as executor or administrator, a certified copy of letter of administration or probate is required)		
6. Are you of the full age of 18 years?	☐ Yes ☐ No	If No what is your date of birth? (dd/mm/yyyy)	
7. Place of death			
8. If death due to accident, suicide, homicide, please specify:			

Please provide police report based on the cause of death specified in #8 of section 2

Witness : _____ Claimant: _____

Date: _____ Address: _____

Note: Attach birth certificate and death certificate (original or certified copy)

SECTION 3 **ATTENDING PHYSICIAN'S STATEMENT**

1. Name of the deceased:	
2. Date of death:	
3. Did you attend to the deceased during his last illness?	
4. Chief or Primary cause of death:	
5. Contributing or Secondary cause:	
6. Date of commencement of illness:(YYYY/MM/DD)	
7. If death was caused by accident, was such accident associated with his occupation?	

I CERTIFY that above information is correct to the best of my knowledge.

Date: _____ Signature: _____ M.D

Address: _____