

Generali Worldwide

Health Insurance – Proof of Death Form



Please complete all sections in **BLOCK CAPITALS** or tick the boxes, where appropriate.

Group name:	<input type="text"/>		
Group Number:	<input type="text"/>	Policy ID number:	<input type="text"/>
Deceased is insured as:	Employee <input type="checkbox"/>	Spouse <input type="checkbox"/>	Child <input type="checkbox"/>
1. Deceased's name in full:	<input type="text"/>		
2. Residence at death: (Street, City and Country)	<input type="text"/>		
3. a) Date of deceased's birth:	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Place of deceased's birth:	<input type="text"/>		
4. a) Date of death:	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Place of death:	<input type="text"/>		
c) Cause of death:	<input type="text"/>		
5. a) When did the deceased first complain of or give other indication of his/her last illness?	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) When did the deceased first consult a physician for his/her last illness?	<input type="text"/>	<input type="text"/>	<input type="text"/>
6. a) On what date did deceased last attend to his or her usual duties?	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Occupation at date of death:	<input type="text"/>		

7. Name and address of all physicians who attended the deceased during his/her last illness and during three years prior thereto:

Names	Address	Dates of Attendance	Disease or Impairment
		M M D D Y Y	
		M M D D Y Y	
		M M D D Y Y	
		M M D D Y Y	
		M M D D Y Y	
		M M D D Y Y	
		M M D D Y Y	
		M M D D Y Y	

8. In what capacity or by what title, do you claim this insurance? Age

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The undersigned hereby makes claim to the said insurance in this company and agrees that the written statements and affidavits of all the physicians who attended or treated the Insured and all other papers called for shall constitute and they are hereby made a part of these proofs of death, and further agrees that the furnishings of this form, or any forms supplemental thereto by the company shall not constitute nor be considered an admission by it that there was any insurance in force on the life in question, nor a waiver of any of its rights or defences.

Dated at _____ this _____ day of _____ 20 _____

Signature of Claimant:	Date: <table border="1" style="display: inline-table; text-align: center; width: 60px;"> <tr> <td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td> </tr> </table>	M	M	D	D	Y	Y
M	M	D	D	Y	Y		

Witness:	
City:	
Country:	
P.O. Box:	

Office: Generali Worldwide, 2nd Floor, Campbell Maritime Centre, West Bay Street, Nassau, Bahamas.

Mailing Address: Generali Worldwide, P.O. Box AP-59217, Slot 2052, Nassau, Bahamas.

Licensed by the Insurance Commission of the Bahamas to carry on long-term insurance business in the Commonwealth of the Bahamas.

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salesbahamas@generali-worldwide.com

Generali Worldwide is a trading name of Utmost Worldwide Limited

Registered Head Office address: Utmost Worldwide Limited, Utmost House, Hirzel Street, St Peter Port, Guernsey, Channel Islands GY1 4PA.

Regulated in Guernsey as a licensed insurer by the Guernsey Financial Services Commission under the Insurance Business (Bailiwick of Guernsey) Law, 2002 (as amended).

Incorporated in Guernsey under Company Registration No. 27151.

generali-healthcare.com

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