Generali Worldwide
Health Insurance – Proof of Death Form

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

Group name:

Group Number: Policy ID number:

Deceased is insured as: Employee ☐ Spouse ☐ Child ☐

1. Deceased's name in full:

2. Residence at death:
(Street, City and Country)

3. **a)** Date of deceased's birth: M M D D Y Y

b) Place of deceased's birth:

4. **a)** Date of death: M M D D Y Y

b) Place of death:

c) Cause of death:

5. **a)** When did the deceased first complain of or give other indication of his/her last illness? M M D D Y Y

b) When did the deceased first consult a physician for his/her last illness? M M D D Y Y

6. **a)** On what date did deceased last attend to his or her usual duties? M M D D Y Y

b) Occupation at date of death:

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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

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: M M D D Y Y

Witness:

City:

Country:

P.O. Box:

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