PAN AMERICAN LIFE
INSURANCE OF TRINIDAD AND TOBAGO
A member of the Pan-American Life Insurance Group

CLAIMANT'S STATEMENT

PROOF OF DEATH

Submitted on behalf of:

1. NAME OF INSURED If married female, give maiden name also	1
2. INSURED'S RESIDENT ADDRESS AT DEATH	2
2a. Date of birth	a. Day / Month / Year
2b. Place of birth	b.
3. Date of death	3 Day / Month / Year
3a. Place of death	a.
4. Occupation at time of death	4
4a. Date last worked full time at full pay	a. Day / Month / Year
5. Cause of Death	5
5a. When did insured first complain or give other indications of last illness?	a.
5b. When did insured first consult a physician for last illness?	b.
6. List all Physicians who attended the insured during last illness and during three (3) years prior thereto.	6

The undersigned hereby makes claim to said insurance, 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 herein, shall constitute and they are hereby made part of these Proofs of Death, and further agrees that furnishing of this form, or of any other forms supplemental thereto, by said Company, shall not constitute there nor be considered by it that was any insurance in force on the life in question, nor a waiver of any of its rights or defenses.

Dated _____ **Claimant** _____

Relationship to Insured _____

Witness _____ **Contact Phone #** _____
FCIB Representative

FOR BANK USE ONLY

Insured's Certificate Number(s)	1)	2)	3)
Effective date of coverage			
Insured's account balance as of date of death			
Date of last premium paid			
Amount of last premium paid			