FOREIGN DEATH QUESTIONNAIRE

Claim Dept. - 5310
P.O. Box 21008, Greensboro, NC 27420-1008
Phone: 800-487-1485

Overnight Address:
Lincoln Financial Group
Claim Dept. – 5310
100 North Greene Street, Greensboro, NC 27420-1008

For use with claims on policies issued by:

Aetna Life Insurance Company
Cigna Life Insurance Company
Connecticut General Life Insurance Company
First Penn-Pacific Life Insurance Company
The Lincoln National Life Insurance Company and Lincoln Life & Annuity Company of New York (collectively Lincoln)
Voya Retirement Insurance and Annuity Company

FOREIGN DEATH QUESTIONNAIRE- Complete all sections below (1 – 7)

1. Enter Your Claim and Policy Information

Claim Number:	Policy Number:

2. Enter Personal Information of Deceased

First Name:	Middle Name:	Last Name:	
Last address in the U.S.A. (not P.O.Box):			Apt/Suite Number:
City:	State:	Zip Code:	Social Security Number / TIN Number:
Date of Birth (mm/dd/yyyy):	Place of Birth:		Date of Death (mm/dd/yyyy):
Was the deceased a U.S. citizen? ☐ Yes ☐ No	If No, Country of Citizenship:		Passport Number:
Occupation Title:	Employer Name:		
Employer Address:	Apt/Suite Number:	State:	Zip Code:
Last Date Worked (mm/dd/yyyy):	Phone Number:		
Did the deceased have any other life or accidental Death coverage? ☐ Yes ☐ No			
If Yes, please provide the name, address of issuing company and the policy number:			
Name:	Issuing Company:	Policy Number:	
Mailing Address:	Phone Number:	Fax Number:	
City:	State:	Zip Code:	
Name:	Issuing Company:	Policy Number:	
Mailing Address:	Phone Number:	Fax Number:	
City:	State:	Zip Code:	

3. Enter Travel Information

Date deceased departed the U.S.(mm/dd/yyyy):	Intended duration of trip:	Intended itinerary (attach copy)
Purpose of trip:		

Travel companions

Name	Address	Phone Number
Was a Travel Agent used? ☐ Yes ☐ No If Yes, provide name and address:		Travel Agent Phone Number:
Travel Agent Name:		
City:	State:	Zip Code:

Airline used when departing the U.S.

Departure airport:	Interim airports:	Arrival airport:
Was a return flight booked? If yes, provide the ticket information:		

4. Enter Health Information of Deceased

Please note any significant health conditions the deceased had been diagnosed with or treated for prior to taking the trip.

Please list any medications the deceased was taking at the time of departure.

Medication Name	**Dosage Amount**	**Purpose**

What was the deceased's overall health status at the time of departure?	
Exact location of Death:	
Exact cause of Death:	Manner of Death: ☐ Accidental Death ☐ Homicide ☐ Natural Death ☐ Suicide
Nature of Illness:	Date Illness began (mm/dd/yyyy):
Circumstances leading to Death:	
Foreign address at time of Death: ☐ Hotel ☐ Private home of ______________________ ☐ Other __________________________________	
Mailing Address:	
Details of Death (attach a copy of any official report)	

Physician's Information in the U.S.

Physician Name:			Physician Specialty:
Current Physician: ☐ Yes ☐ No	Date Last Seen (mm/dd/yyyy):		Phone Number:
Mailing Address:			Fax Number:
City:		State:	Zip Code:

Names and addresses of witnesses

Name	Address
Name	Address
Name	Address

Names and addresses of police department involved (attach copy of any official report)

Name	Address
Name	Address
Name	Address

Please list the names and addresses of all hospitals and facilities that treated the deceased

Hospital Name:	Date Admitted (mm/dd/yyyy):	Date Discharged (mm/dd/yyyy):
Mailing Address:	Phone Number:	Fax Number:
City:	State:	Zip Code:
Hospital Name:	Date Admitted (mm/dd/yyyy):	Date Discharged (mm/dd/yyyy):
Mailing Address:	Phone Number:	Fax Number:
City:	State:	Zip Code:
Hospital Name:	Date Admitted (mm/dd/yyyy):	Date Discharged (mm/dd/yyyy):
Mailing Address:	Phone Number:	Fax Number:
City:	State:	Zip Code:

Please list the names and addresses of all attending physicians who treated the deceased

Physician Name:		Physician Specialty:	
Current Physician: ☐ Yes ☐ No	Phone Number:	Fax Number:	
Mailing Address:			
City:		State:	Zip Code:

Physician Name:		Physician Specialty:
Current Physician: ☐ Yes ☐ No	Phone Number:	Fax Number:

Mailing Address:			
City:		State:	Zip Code:
Physician Name:		Physician Specialty:	
Current Physician: ☐ Yes ☐ No	Phone Number:	Fax Number:	
Mailing Address:			
City:		State:	Zip Code:
Name of physician certifying the Death:	Was there an autopsy? ☐ Yes ☐ No	Was there a post mortem inquest? ☐ Yes ☐ No	
Was the U.S. Embassy or Consulate involved? ☐ Yes ☐ No If yes, please give details and attach a copy of Report of Death of an American Citizen Abroad.		**Note:** Please attach any newspaper articles related to the insured's Death.	

5. Enter Burial / Cremation Information

Deceased was: ☐ Buried ☐ Cremated ☐ Entombed	
Name and Address of Funeral Home:	
What documentation was obtained to permit burial or cremation: (attach copies)	
Name, address and relationship of person who made the arrangements:	Date of funeral or memorial service:
Funeral Home Name, Address and Phone #:	
Funeral Director Name:	

6. Enter Personal Information of Claimant

Signature – Claimant

By signing below, I hereby declare that the foregoing information is true to the best of my knowledge.

Claimant's Legal Name, First, MI, Last, Suffix (Please Type or Print):		
Mailing Address:	Apt/Suite Number:	
City:	State:	Zip Code:
Claimant's Signature:	Date (mm/dd/yyyy):	
Relationship to deceased:	Date of Birth (mm/dd/yyyy):	

Authorization to Obtain Information and Signatures

The purpose of this authorization is to obtain confidential records that will allow us to determine eligibility for a claim for benefits under a life insurance policy.

You authorize any physician, or medical professional, hospital, pharmacy, clinic or other medically-related facility, insurer or reinsurer, Medical Information Bureau, Inc., the Social Security Administration, EQUIFAX Services, Internal Revenue Service, governmental agency, or employer having information or records relative to age, finances, occupation and employment, other insurance coverage, participation in hazardous activities, or the medical care, advice, treatment, or supplies furnished with respect to any physical or mental condition, including information relating to the use of drugs or alcohol, of the patient, employee, or deceased person described below to furnish such information or records to the insurance company named below (Company), its reinsurers, agents, or any insurance support organization acting on "the Company's" behalf.

Fair Credit Reporting Act - As a part of our routine procedure for evaluating a claim, we may request that an Investigative Consumer Report be made. The insurance support organization or Consumer Reporting Agency making the report may obtain a copy of the report and disclose its contents to others for whom it performs such services. This report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics.

Additional information is usually obtained from several different sources, including public records. Confidential interviews may be conducted with neighbors, friends, business associates and acquaintances. Past experience reflects that in most cases information from Investigative Consumer Reports usually does not have an adverse effect on the claim decision. If the Investigative Consumer Report does have an adverse effect on a claim decision, we will notify you in writing and identify the reporting agency. At that time, you have the right to discuss the matter with the reporting agency if you choose to do so.

All of these rights are guaranteed to you by the Fair Credit Reporting Act, which took effect in April, 1971. The procedures outlined by this law are consistent with "the Company's" long standing position concerning consumer reports and "the Company" fully supports this legislation.

Confidentiality - Information collected will not be given to anyone without your consent, except when it is necessary for conducting our business. The only people who have access to the information are employees or reinsurers who service your policy, and those who have insurance-related regulatory, or legal need for the information. In any other situation, we will ask for written authorization to disclose information.

If you would like to know what information we have obtained from a Consumer Reporting Agency about you (or the deceased person named below), please write to the address above.

This authorization shall be valid for the life of the claim. A photographic copy of this authorization shall be as valid as the original.

You will be given a copy of this authorization at your request. An Investigative Consumer Report may be obtained and if such a report is obtained, you may request to be interviewed in connection with the preparation of that report. If a consumer report is obtained,

☐ You do request to be interviewed.
☐ You do not request to be interviewed.

7. Enter Insured Information

<table>
<tr><td colspan="3">Insured Name, First, MI, Last, Suffix (Please Type or Print):</td></tr>
<tr><td>Policy Number(s):</td><td colspan="2">Insurance Company's Name:</td></tr>
<tr><td>Name of person completing this form, if different from Insured:</td><td colspan="2">Relationship to Insured, if Insured is deceased:</td></tr>
<tr><td colspan="2">Signature of Insured or person completing this form:</td><td>Date (mm/dd/yyyy):</td></tr>
</table>