Lincoln Financial Group℠

Claims Department
PO Box 21008
Dept 0514
Greensboro, NC 27420-1008
Phone 800-487-1485

FOREIGN DEATH QUESTIONNAIRE

Personal Information of Deceased

Name of Deceased: _____

Last Address in the U.S. (Not P.O. Box): _____

Date of Birth: _____ Place of Birth: _____

Was the Deceased a U.S. Citizen? ☐ Yes ☐ No If No, Country of Citizenship: _____

Social Security Number/ Tax ID Number: _____

Passport Number: _____

Occupation: _____

Employer Name: _____

Employer Address: _____

Employer Telephone Number: _____

Date Last Worked: _____

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:

_____

_____

_____

Purpose of Trip: _____

Travel Information

Date Deceased left the U.S. _____

Intended Duration of Trip: _____

Intended Itinerary (Attach Copy): _____

Travel Companions:

Name: _____

Address: _____

Telephone Number: _____

Name: _____

Address: _____

Telephone Number: _____

Name: _____

Address: _____

Telephone Number: _____

Name: _____

Address: _____

Telephone Number:_____

Was a Travel Agent used? ☐ Yes ☐ No If Yes, Provide Name, Address and Telephone Number:

_____

_____

Airline used when departing the U.S. _____

Airport departing from:_____

Airport departing from:_____

Interim Airports: _____

Airport arrived at: _____

Was a return flight booked? ☐ Yes ☐ No If Yes, give ticket information:

_____

Health Information of Deceased

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

_____

_____

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

_____

_____

Name, Address and Telephone Number of physician in the U.S.

Physician Name: _____

Physician Address: _____

Physician Telephone Number: _____

What was the deceased's overall health status at the time of departure? _____

Details of Death

Foreign Address at the Time of Death:

Nature of Address: ☐ Hotel ☐ Private home of _____ ☐ Other_____

Exact place of Death: _____

Exact cause of Death: _____

Accidental Death

Details of Accident: (Attach a copy of any official report)

_____

_____

Name, Address and Telephone Number of Witnesses:

Witness Name: _____

Witness Address: _____

Witness Telephone Number: _____

Witness Name: _____

Witness Address: _____

Witness Telephone Number: _____

Name, and Address of Police department involved: (Attach copy of any official report)

_____

_____

Natural Death

Nature of Illness: _____ Date Illness Began: _____

Circumstances Leading to Death: _____

In Either Case

Name, Address and Telephone Number of all Hospitals and Facilities that treated the Deceased:

Hospital Name: _____

Hospital Address: _____

Hospital Telephone Number: _____

Hospital Name: _____

Hospital Address: _____

Hospital Telephone Number: _____

Name, Address and Telephone Number of all attending physicians who treated the Deceased:

Physicians Name: _____

Physicians Address: _____

Physicians Telephone Number: _____

Name of Physician Certifying the Death: _____

Was there an autopsy? ☐ Yes ☐ No Was there an 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.

Please attach any newspaper articles related to the insured's death.

Burial/Cremation

Deceased Was: ☐ Buried ☐ Cremated ☐ Entombed

Name, Address and Telephone Number of Funeral Home:

Funeral Home Name: _____

Funeral Home Address:_____

Funeral Home Telephone Number:_____

What documentation was obtained to permit burial or cremation: (Attach Copies)

_____

Name, Address and Relationship of Person who made the arrangements:

Name: _____

Address: _____

Relationship: _____

Date of Funeral or Memorial Service: _____

Name, Address and Telephone Number of Funeral Home:

Funeral Home Name: _____

Funeral Home Address:_____

Funeral Home Telephone Number:_____

Name of Funeral Director: _____

Personal Information of Claimant

Name: _____

Address: _____

Relationship of Deceased:_____

Date of Birth: _____

I hereby declare that the foregoing information is true to the best of my knowledge.

_____ _____

Signature Date