

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