Foreign Claim Questionnaire

To be completed for claims involving loss outside the United States.

Clear Form

Clear Kit

NORTH AMERICAN®

Information

Type of Claim: ☐ Life/Death Claim ☐ Accidental Claim

Name of Deceased:	Policy Number(s):
Last address in the U.S. (Canada):	
Date of Birth:	Place of Birth:
Citizenship:	Passport Number:
U.S. Citizen: ☐ Yes ☐ No	If no, date first entered the U.S.
Occupation:	Social Security Number:
Details of any other insurance coverage:	

Travel Information

Date deceased left U.S. (Canada):	Intended duration of trip:
Intended itinerary:	
Purpose of trip:	
Airline used when departing U.S. (Canada):	
Airport Departed From:	Airport Arrived At:
Was return flight booked: ☐ Yes ☐ No	If yes, give ticket information:

Details of Death

Date and time of death:	Exact place of death:
Exact cause of death:	
Foreign address at time of death:	

A. Accident

Details of accident:

Names and addresses of witnesses:

Name of police officer and police department involved:

B. Natural Causes

Name of illness:	Date illness began:

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In either case:

Name/Address of any hospital involved:

Name(s), address, phone number of attending physicians:

Name, address, phone number of physician certifying death:

Any Autopsy?: ☐ Yes ☐ No	Any post mortem or inquest?: ☐ Yes ☐ No

Name, address, phone number of coroner:

U.S. Embassy or Consulate contacted?: ☐ Yes ☐ No	If yes, give details:

Burial/Cremation

Was deceased buried or cremated?: ☐ Yes ☐ No

Where did this occur:

What documentation was obtained to permit burial or cremation:

Provide names, addresses, phone numbers, and relationships of immediate family members who were present at the funeral/burial/cremation:

Provide names, addresses, phone numbers, and relationships of two people, not related to the deceased, who were present at the funeral/burial/cremation:

Please send any of the documents available:

☐ Visa	☐ Burial Permit	☐ Original Death Certificate	☐ Hospital Bills
☐ Passport	☐ Doctor Bills	☐ Birth Certificate	☐ Report of Death of American Citizen*
☐ Obituary	☐ Copies of Medical Records for past year	☐ Police Report	(from U.S. Embassy)
☐ Photo of Deceased	☐ Airline Tickets (To/From U.S.)	☐ Newspaper Clipping(s)	*Required if insured is a U.S. Citizen

Personal Information of Claimant/Beneficiary

Name:

Address in U.S. (Street Address, City, State, ZIP):

Date of Birth:	Place of Birth:

Foreign Address:

U.S. Citizen?: ☐ Yes ☐ No	Date first entered U.S.	Did you attend the funeral/burial service?: ☐ Yes ☐ No

I certify, under penalty of perjury, the following is my correct Social Security Number or Taxpayer Identification Number:

Beneficiary/Payee signature (Required):	Date (mm/dd/yyyy):

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime.

I hereby certify that the above information is correct and declare that all answers as above recorded are complete and true and agree that the furnishing of this additional, supplemental information shall not constitute an admission of liability nor a waiver of any of the company's rights and defenses.

Claimant/Beneficiary signature:	Date (mm/dd/yyyy):
Witness:	

Please return this form along with a completed and signed Authorization for Release of Information.