

# Foreign Claim Questionnaire

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



## 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:



\*O-2796\*

**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  NoAny 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  
 Passport  
 Obituary  
 Photo of Deceased

Burial Permit  
 Doctor Bills  
 Copies of Medical Records for past year  
 Airline Tickets (To/From U.S.)

Original Death Certificate  
 Birth Certificate  
 Police Report  
 Newspaper Clipping(s)

Hospital Bills  
 Report of Death of American Citizen\*  
 (from U.S. Embassy)

\*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.

**CA Residents:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Claimant/Beneficiary signature:

Date (mm/dd/yyyy):

Witness:

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