

**PROOFS OF DEATH**

**No.1 Claimant Statement**

SUBMITTED TO

**American International Assurance Co., Ltd.**

INCORPORATED UNDER THE COMPANIES ORDINANCES, HONG KONG  
(A Member Company of American International Group)

**DEATH CLAIM - CLAIMANT'S STATEMENT**

Please read instructions on the following page before filling out this statement

Number of policies in this company	Amounts
_____	_____
_____	_____

Deceased's name in full:	Age:
_____	_____

1.	Residence at death			
2.	Occupation at date of death			
3.	(a) Date and place of deceased's birth	Date:	Place:	
	(b) Source from which date of birth obtained (Family record or other record or certificate of birth should be referred to):			
4.	(a) Date and place of death	Date:	Place:	
	(b) Cause of death			
5.	(a) When did the deceased first complain of or give other indication of his last illness?			Date:
	(b) When did the deceased first consult a physician for his last illness?			Date:
6.	On what date deceased last attend to his usual work?			Date:
7.	Was an inquest or post mortem examination held on the body? If so, furnish certified copy of verdict or findings.			
8.	Names and addresses of all physicians who attended deceased during his last illness and during three years prior thereto:			
	Name	Addresses	Date of Attendance	Disease or Condition
9.	With what other companies, and for what amounts, was the life of deceased assured?			
	Companies	Policies Dated	Amounts of Assurance	
10.	How long have you known deceased?			
11.	In what capacity, or by what title, do you claim this assurance?			
12.	Who has possession of the policy?			
13.	Do you elect one of the optional modes of settlement? If so, which mode of settlement?			
14.	What is your present age?			

The undersigned hereby makes claim to said assurance in American International Assurance Co., Ltd. and agrees that the written statements and affidavits of all the physicians who attended or treated the Assured and all other papers called for by the instructions hereon, shall constitute and they are hereby made a part of these Proofs of Death, and further agrees that the furnishing of this form, or of any other forms supplemental thereof, by said Company shall not constitute nor be considered an admission by it that there was any assurance in force on the life in question, nor a waiver of any of its rights or defenses.

Dated at _____	Signature: _____
this _____ day of 20 _____	Name: _____
Witness _____	IC No. _____
Name/ IC No. _____	Tel. No. _____
Address: _____	Address: _____
_____	_____

(PT 0007001)

## DEATH CLAIM FORM – IMPORTANT INSTRUCTIONS

In ordinary cases, the proofs of death required are as follows:

1. STATEMENT No. 1 (CLAIMANT STATEMENT) must be made by the person or persons to whom the assurance is payable. If there is more than one beneficiary, all may join in one statement, or a separate blank will be furnished for each desired.
2. When a policy is payable to the estate or executors or administrators of the assured, the statement must be made by the executor or administrator, a certificate of whose appointment and qualification must be furnished.
3. When a policy is payable to a named beneficiary of full age, the statement must be made by such beneficiary.
4. When a policy is payable to a minor, the statement must be made by a guardian, an official certificate of whose appointment and qualification must be furnished.
5. When a policy has been assigned, the statement must be made by the assignee. (Further requirement to be decided by Company)
6. When a policy is payable to a named beneficiary or to one or more beneficiaries and by the death of any beneficiary has become otherwise payable, a certified copy of the death certificate of the deceased beneficiary must also be furnished.
7. When a policy, or any of it, is payable to "children" or others of a class, a sworn statement must be furnished, giving the names and dates of birth of each. If any have died, the statement must give the date and place of death, and must also state whether they died unmarried, intestate, and without issue.
8. When an official inquiry as to the cause of death has been made, a copy of the verdict, or findings, duly certified must be furnished with this statement.
9. STATEMENT No. 2 (PHYSICIAN STATEMENT) must be made by every physician who attended the deceased during the last illness, and for this purpose the company will furnish as many Statement No. 2 forms as are required.
10. Every question must be distinctly and fully answered. The company reserves the right to require or to obtain further information should it be deemed necessary.
11. Instructions are found with each blank to be filled in the form. Each person required to answer the questions are requested to read carefully and understand the instruction before filling in the form.

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### PHYSICIAN'S STATEMENT

Please read instructions on the following page before filling out this statement

Name of Deceased Life Assured:

1.	(a) Please quote the deceased's identity card number from your record	
	(b) Place at time of death	
	(c) Occupation	
2.	(a) Were you the deceased's ordinary medical attendant?	
	(b) If so, for how long?	
	(c) If not, give the name of the usual attendant, if known to you.	
	(d) Give the names and addresses of any other practitioners who to your knowledge attended to the deceased during the past three years.	
	(e) Did you attend to the deceased during his/ her last illness? If so, for what complaint?	
	(f) On what date did you first see and treat the deceased?	
	(g) Were you present at the time of death? If not, on what date did you last treat the deceased?	
	(h) Have you treated the deceased for any other illness? If so, for what complaint and when?	
3.	(a) What was the primary cause of death and its duration?	
	(b) From what other significant disease did the deceased suffer and for how long?	
4.	For how long was the deceased hospitalised, confined to house or prevented from attending to business?	
5.	Was there any predisposing cause of the deceased's death in his/ her habits (use of alcohol, narcotics, etc.), family history, occupation or previous sickness?	
6.	Please give any other information you feel may be relevant.	

I hereby declare that the foregoing answers are each and all true to the best of my knowledge and belief.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_

Professional Qualifications: \_\_\_\_\_

Date: \_\_\_\_\_

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## COMPANY'S STATEMENT

Please read instructions on the following page before filling out this statement

Name of Deceased Life Assured:

1.	Was the deceased in the full time employment (i.e. on the payroll) of the policyholder at the time of death?

2.	If not, when was his/ her employment terminated?

3.	When was the last day he/ she was actively at work?

Name of Company: \_\_\_\_\_

Address of Company: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Statement completed by: \_\_\_\_\_

Designation: \_\_\_\_\_

  

Signature: \_\_\_\_\_ Date: \_\_\_\_\_