



Life Insurance Program from



## Foreign Death Questionnaire

### Personal Details of the Deceased

Name of Deceased: \_\_\_\_\_ Contract #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Nationality: \_\_\_\_\_  
Month Day Year

Normal Residential Address: \_\_\_\_\_  
Street Address City State Zip Code

Citizenship: \_\_\_\_\_ Passport Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ Last Employer: \_\_\_\_\_

### Travel Details

Purpose of visit abroad: \_\_\_\_\_

Date of departure: \_\_\_\_\_ Method of Travel, i.e. air, sea: \_\_\_\_\_  
Month Day Year

Address while abroad: \_\_\_\_\_  
Street Address City State or Country Zip Code

Intended duration of trip? \_\_\_\_\_ Did the Deceased travel alone?  Yes  No

If not traveling alone, please provide names addresses and telephone numbers of persons accompanying him/her.

### Particulars of Death

Date and Time of Death: \_\_\_\_\_ Place of Death: \_\_\_\_\_

Country of Death: \_\_\_\_\_ Cause of Death: \_\_\_\_\_

Name/Address of Doctor certifying death: \_\_\_\_\_

Place and Date of registration of death: \_\_\_\_\_

Was the deceased buried or cremated? \_\_\_\_\_

Date and Place of Burial: \_\_\_\_\_

**Cause of Death/Medical History**

**ACCIDENTAL CAUSES**

Details of accident: \_\_\_\_\_

Date/Time of admittance to hospital: \_\_\_\_\_

Name and address of hospital: \_\_\_\_\_

Name and address of Police Station: \_\_\_\_\_

Details of the police officer's findings: \_\_\_\_\_

**ILLNESS**

Details of illnesses in previous 5 years: \_\_\_\_\_

Name and address of family doctor: \_\_\_\_\_

Details of illness abroad leading to death: \_\_\_\_\_

Names/Addresses of hospitals attended and doctors names: \_\_\_\_\_

**Declaration**

I authorize any doctor, medical establishment or other insurance company to release to New York Life Insurance Company or its appointed representative any medical or other information relating to the deceased. All the information provided is true and complete to the best of my knowledge.

Signature of Claimant Relationship to Insured Date

**Witness:** I hereby confirm the authenticity of the signature of the claimant.

Signature of Witness Print Name

