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.

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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: ______________________

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ILLNESS

Details of illnesses in previous 5 years: ______________________

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Name and address of family doctor: ______________________

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Details of illness abroad leading to death: ______________________

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Names/Addresses of hospitals attended and doctors names: ______________________

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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.

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Signature of Claimant | Relationship to Insured | Date

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

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Signature of Witness | Print Name