GLICO LIFE INSURANCE CO. LTD, P.O.BOX 4251, ACCRA
TEL: 0302 246 140/0302 670 335

DEATH CLAIM FORM

NOTE: completed claim form to be submitted together with (1) Proof of title of claimant;(2)Proof of age of deceased;(3)Policy document;(4) Death Certificate; (5) Certificate of cause of death.

1. PARTICULARS OF DECEASED

a. Name: _____ Policy No:. _____
b. Staff No.: _____ Management Unit/Payroll No.: _____
c. Address: _____ Age: _____
d. Business Occupation: _____ Date of Birth: _____

2. NAME OF HOSPITAL

a. Place of Death: _____ Date of Death: _____
b. Folder/OPD No.: _____ Ward: _____
c. Cause of Death: _____
d. Occupation at time of Death: _____

3. HISTORY

a. When did the insured first complain/gave indications of last illness? _____
b. When did the insured first consult a Physician for the last illness? _____
c. State the details of all Physicians who attended to the insured during the last illness as well as three years prior thereto.

NAME	ADDRESS	DATES	REASONS

4. OTHER LIFE POLICIES

a. Has the insured got other life insurance policies? If yes, please complete the following:

NAME	POLICY NO.	POLICY DATE	AMOUNT

5. PARTICULARS OF CLAIMANT

a. Name of Claimant: _____
b. Claimant's Date of Birth: _____
c. Address of Claimant: _____
d. Relationship with the deceased: _____
e. Have you enclosed policy documents? _____
f. What mode of settlement do you prefer? _____

DECLARATION

I declare that the above answers are true and correct to the best of my knowledge.

Signature: _____ Date: _____

Contact No: _____ Email Address: _____

CLAIMANT TO NOTE:

STATEMENTS made shall be investigated. Any person who makes a claim based on any representation of the existence of a state of fact, knowing full well that the representation is false, stands the risk of having the claim repudiated as well as her/him being prosecuted for defrauding by false pretence contrary to section 131 of the Criminal Code Act 29.

MEDICAL CERTICATE

CAUSE OF DEATH

THIS MEDICAL CERTIFICATE IS TO BE COMPLETED BY A DULY QUALIFIED AND REGISTERED MEDICAL PRACTITIONER WHO LAST ATTENDED TO THE INSURED BEFORE DEATH.

1. Name of Deceased: _____
2. Folder/OPD No: _____
3. Name of Ward: _____
4. Deceased Date of Birth : _____
5. What was death attributed to: _____
6. What was the cause of Death: _____
7. When did the patient first show symptoms of the disease?_____
8. Please give details of Cause of Death? _____

_____

_____

_____

DETAILS OF DOCTOR:

Name of Doctor: _____

Name and Address of Hospital: _____

Tel No.: _____ Code: _____

Email Address: _____ Fax: _____

Doctors Signature: _____ Date: _____

Hospital Stamp: _____

CLIAMANT TO NOTE:

STATEMENTS made shall be investigated. Any person who makes a claim based on any representation of the existence of a state of fact, knowing full well that the representation is false, stands the risk of having the claim repudiated as well as her/him being prosecuted for defrauding by false pretence contrary to section 131 of the Criminal Code Act 29.