FijiCare

INSURANCE LIMITED

TERM LIFE CLAIM FORM

POLICY NO: _____ **FNPF/EDP NO:**_____

Deceased's Name at Birth: _____

Deceased's Name at Death: _____

Last address: _____

Occupation: _____

Date of Death: _____ Cause of Death: _____

Duration of illness: _____ Date of Birth: _____

Name/s and Address of usual Doctor and treating Doctor: _____

_____

Details of Hospital Treatment over the last 12 months (Names of Hospitals and admission dates): _____

_____

_____

**(if insufficient space for any answer please attach a separate page).*

DISCHARGE

I, _____of _____

_____declare that I am over 18 years of age and that I am legally entitled to claim the proceeds of the said policy being the *_____ of the Deceased, and I undertake to indemnify the Company against any loss it may occur in paying the proceeds to me, should I be called upon to do so, and that the particulars which are given above are true and correct.

Dated at _____ this _____ day of _____, 20_____

Signature of Claimant: _____ Witnessed By: _____

(Signature to be witnessed by a Justice of Peace or Insurance Broker except where signed in the presence of an Officer of the Company).
**State in what capacity you claim, whether as Father, Mother, Widow, Widower or other relation, or as nominated beneficiary, Assignee, Trustee, Executor, or Administrator of Estate, etc.*

Level 9, FNPF Place, 343-359 Victoria Parade, Suva, Fiji Phone (679) 330 2717 Fax (679) 330 2119