FijiCare

FUNERAL BENEFIT CLAIM FORM

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

Deceased's Name at Birth _____

Deceased's Name at Death (complete if different) _____

Last address _____

Occupation _____

Date of Death _____ Cause of death _____

Duration of illness _____ DOB _____

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

_____

Details of Hospital Treatment over the last 12 months (Name/s of Hospital/s 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 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_____.

Claimant _____ Witness _____

(Signature to be witnessed by the liaison person of the Insured Group or 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.*

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