Life Insurance Claim Form Instructions

Documentation required upon submitting a Life Insurance Claim:

Upon death of an Insured Person, the Beneficiary shall notify providers without delay. In addition, please submit the following documents to Provider as soon as possible:

- Life Insurance Claim Form (see Page 2);
- An official certificate of death, indicating date of birth of the deceased Insured Person;
- Proof of employment;
- Proof of salary, if benefit is salary related;
- A detailed medical report on the onset and course of the disease, bodily injury or accident which caused death;
- In the event of no medical treatment, a medical or official certificate stating the cause and circumstances of death.

Providers are entitled to obtain further information. Expenses incurred in relation to the substantiation of a claim have to be borne by the claimant. Providers will pay the insured benefit as soon as it has satisfied itself of the validity of the claim based on its assessment of the required documents that have been received.

Claim form and documents can be submitted to:

Email: LifeClaims@trawickinternational.com
Fax: +1 251-666-1806
Mail: Trawick International
ATTN: Life Claims
PO Box 2069
Fairhope, AL 36533 USA

Life Insurance Claim Form

PART I - TO BE COMPLETED BY EMPLOYER OR ORGANIZATION	
A. EMPLOYER INFORMATION	
Employer:	
B. INSURED INFORMATION	
Name of Insured (Last, First, Middle):	
Policy #:	Trawick ID #:
Date of Birth (DOB): (DD/MMM/YYYY, i.e., 23/NOV/1988)	From what record was DOB obtained:
Occupation:	
Employment Category:	
Annual Salary:	
C. EMPLOYER AUTHORIZATION	
Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.	
Signature:	
Name (Last, First, Middle):	
Title:	
Email:	Date of Birth: (DD/MMM/YYYY, i.e., 23/NOV/1988)

Life Insurance Claim Form

PART II – TO BE COMPLETED BY CLAIMANT	
A. INSURED INFORMATION	
Name of Deceased (Last, First, Middle):	
Date of Birth (DOB): (DD/MMM/YYYY, i.e., 23/NOV/1988)	From what record was DOB obtained:
Employer (if applicable):	Country of Residence:
B. CLAIMANT INFORMATION (Beneficiary)	
Name (Last, First, Middle):	Relationship to Deceased:
Date of Birth: (DD/MMM/YYYY, i.e., 23/NOV/1988)	Claimant's SSN (if applicable):
Address:	
Postal Code:	Country:
C. CLAIM INFORMATION	
Date of Death: (DD/MMM/YYYY, i.e., 23/NOV/1988)	Place of Death:
Cause of Death:	
When did health of deceased first become impaired? (DD/MMM/YYYY, i.e., 23/NOV/1988)	
In last illness, when did deceased first consult a physician? (DD/MMM/YYYY, i.e., 23/NOV/1988)	
On what date did deceased last attend usual work? (DD/MMM/YYYY, i.e., 23/NOV/1988)	
D. PHYSICIAN INFORMATION	
Physician #1	
Physician / Facility / Provider Name:	
Date of Attendance: (DD/MMM/YYYY, i.e., 23/NOV/1988)	
Seen for:	
Address:	
Postal Code:	Country:
Phone:	Email:

D. PHYSICIAN INFORMATION (continued)	
Physician #2 (if applicable)	
Physician / Facility / Provider Name:	
Date of Attendance: (DD/MMM/YYYY, i.e., 23/NOV/1988)	
Seen for:	
Address:	
Postal Code:	Country:
Phone:	Email:

E. OTHER LIFE OR ACCIDENT INSURANCE ON THE LIFE OF DECEASED		
Policy Dates: (DD/MMM/YYYY, i.e., 23/NOV/1988)	Companies/Associations:	Amount of Insurance:

F. AUTHORIZATION

The undersigned hereby makes claim to said insurance as beneficiary and agrees that the written statements and affidavits of all physicians who attended or treated the insured and all other papers called for by the instructions herein shall constitute and they are hereby made a part of these Proofs of Death, any further agrees that the furnishing of this form or any of the forms supplemental thereto by the Company shall not constitute nor be considered an admission by it that there was any insurance in force on the life in question nor a waiver of any of its rights or defenses.

I expressly waive on behalf of myself and any other party who shall have or claim any interest in any policy issued to the insured, all provisions of law forbidding any physician or any other person who attended or examined the insured, or any hospital or sanitarium in which insured was confined, treated or examined, from disclosing any information or knowledge acquired thereby and I authorize the furnishing of all such information to the above named insurance company. A photocopy of this authorization shall be considered as effective and valid as the original.

Claimant	**Witness**
Name (Last, First, Middle):	Name (Last, First, Middle):
Signature:	Signature:
Date: (DD/MMM/YYYY, i.e., 23/NOV/1988)	Date: (DD/MMM/YYYY, i.e., 23/NOV/1988)

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Fair Processing Notice

Pursuing the Regulations (EU) 2016/679 of 27 April 2016 on the protection of individuals concerning the processing of personal data and on the free movement of such data (known as General Data Protection Regulation) and for the purpose of the management of the insurance contract, the personal data of the Insured Person may be transferred to the Insurer and to its delegates, service providers, subcontractors or reinsurers. Insured Persons are informed that processes concerning them, and their Dependants if any, are implemented for the signing, management and execution of this insurance contract along its commercial management. Personal data may also be used for control operations, fight against fraud and money laundering and the financing of terrorism, search for beneficiaries of unpaid Life contracts and the implementation of legal and regulatory provisions, with respect of the enforcement of this contract. Collected Data are indispensable for the implementation of these processing and are intended for the relevant departments of the Insurer as well as its outsourced Administrator and where applicable, its subcontractors, providers or partners. The Insurer is liable to ensure that this data is accurate, complete, and up to date when necessary. The data collected will be kept for the entire duration of the contract which may be increased by legal prescriptions or in order to be compliant with the periods provided for by the CNIL Commission Nationale de l'Informatique et des Libertés (the French National Commission for Data Protection). These personal data may be transferred to service providers or subcontractors which are established in countries outside of the European Union. Only countries recognized by the European Commission as providing an adequate level of personal data security, or recipients who have appropriate assurances, are eligible for these transfers. Insured Persons and/or Dependants have a right of access, rectification or deletion, limitation of the processing of their data, portability, opposition to processing, along with the right to provide instructions on the outcome of the data after their death. They can exercise their rights towards the Délégué à la Protection des Données du Groupe VYV (Data Protection Officer of the VYV Group): 62-68 rue Jeanne d'Arc – 75013 Paris CEDEX or at dpo@vyv-ib.com. When exercising their rights, a proof of identification may be requested. In the event of a persistent conflict, they have the right to appeal to the CNIL on www.cnil.fr or at 3, place de Fontenoy -TSA 80715 -75334 PARIS CEDEX 7, FRANCE. Data related to medical information on the Insured Persons may be processed for the conclusion, the management and the execution of the contract, as their processing is necessary to fulfill the obligations and to exercise the rights of the Insurer or the rights of the Insured Persons to social protection. These data are exclusively intended for the medical department of the Administrator. The exercise of rights is carried out by mail, along with a proof of identity, to the medical advisor of medical@vyv-ib.com. Legal information MGEN, registered under the number SIREN 775 685 399, regulated by the provisions of Tome II of Code de la mutualité (the French Mutual Insurance Companies Code) and whose head office is located at 3 Square Max-Hymans 75 748 Paris Cedex 15 France. MGEN is represented through an underwriting authority by VYV International Benefits, French Société par actions simplifiée (joint-stock company) with a share capital of EUR 1,000,000, registered at the Registre des commerces et des sociétés (the French Commercial and Company Registry) RCS PARIS under the number 813 361 441 and registered as an insurance intermediary with ORIAS under the number 16002500 and whose head office is located 3 Square Max Hymans 75748 Paris Cedex 15.