FOREIGN DEATH QUESTIONNAIRE

DETAILS OF TRAVEL

Insured's Full Name (please print)			Insured's Phone Number (in the U.S.)
Insured's Home Address (in the U.S.)			
Employer Name (most recent)	Employer Phone	Occupation (please indicate duties if "self-employed")	
Employer Address			
Date Insured left the U.S. to Travel	Method of Travel	Intended Length of Trip	Date of Scheduled Return
Purpose of Trip			
Name of Travel Agency used for last arrangements			Travel Agency's Phone
Travel Agency's Address			
Did the Insured travel by airplane? ☐ Yes ☐ No			
If Yes, please attach a copy of the airline ticket to this form or provide the name of the airline, flight date, time and number			
Name of Airline			
Flight date	Flight Time		Flight Number
Who traveled with the Insured? (Use reverse side of form to list multiple persons)			
Name of person traveling with Insured		Phone number of person traveling with insured	
Address of person traveling with Insured			

Initial_____

FOREIGN DEATH QUESTIONNAIRE

DETAILS OF DEATH		
Foreign Address at time of death		
Telephone Number for above address		
Complete address where death occurred (please include number, street, city, state, province, country)		
Date of Death	Time of Death	
Cause of Death (How did death occur?)		
Name of Person who notified you of the Insured's death (Please provide full name)		Phone Number of Person who notified you
Address of person who notified you of Insured's death		
How were you notified of death?		
Did police investigate insured's death? ☐ Yes ☐ No		
If No, please explain		
Name of Investigating Officer	Station Name	Phone number of Investigating Officer
Address of Investigating Officer		
Name of Hospital(s) where Insured was treated		Phone Number of Treating Hospital(s)
Complete Address of Treating Hospital(s) (please include number, street, city, state, province, country)		
Name of Doctor certifying Death		Phone Number of Doctor certifying death
Address of Doctor Certifying Death		
Was an Autopsy performed? ☐ Yes ☐ No		

FOREIGN DEATH QUESTIONNAIRE

DETAILS OF DEATH CONTINUED

Insured's Death was due to: ☐ Accident ☐ Illnesses ☐ Other

Please specify

Was the Insured ever treated in the U.S. for the illness causing death ☐ Yes ☐ No

If Yes, Name of Treating Facility	Phone Number of Treating Facility

Address of Treating Facility

Was the Insured hospitalized in the last five years? ☐ Yes ☐ No

If Yes, Name of Hospital/Facility	Phone Number of Hospital/Facility	Date of Hospitalization

Address of Hospital/Facility (number, street, city, state, province, country)

Name of Insured's Regular Family Physician	Phone Number of Insured's Regular Family Physician

Address of Insured's Regular Family Physician

Did Insured have any type of health insurance coverage in the last five years? ☐ Yes ☐ No

If Yes, Name of Insurance Carrier	Group Number	Policy Number

DETAILS OF REMAINS

Insured was: ☐ Buried ☐ Cremated

Provide information detailing offices contacted for permits authorizing cremation or burial.

Provide copies of all documentation received allowing cremation or burial.

Name of facility where burial or cremation took place	Phone Number of facility

Complete foreign Address of facility where burial took place

Initial_____

FOREIGN DEATH QUESTIONNAIRE

DETAILS OF REMAINS CONTINUED

Name of Funeral service involved in preparation or transport of the body	Phone Number of funeral service	
Address of Funeral Service		
Name of person who performed the final service	Phone Number	Name of Church
Address of person who performed the final service		

INSURANCE INFORMATION

Did the Insured have any other life insurance in force? ☐ Yes ☐ No

If Yes, please provide Details below

Name of Insurance Company	Policy Number	Coverage Amount

Did the insured ever receive Social Security or State Welfare benefits ☐ Yes ☐ No Starting When?

FAMILY INFORMATION

Name of decedent's parents, (if living): Use reverse side of this form if additional space is needed

Name of Decedent's Parent 1	Phone Number of Decedent's Parent 1
Address of Decedent's Parent 1	
Name of Decedent's Parent 2	Phone Number of Decedent's Parent 2
Address of Decedent's Parent 2	

Initial_____

FOREIGN DEATH QUESTIONNAIRE

FAMILY INFORMATION CONTINUED

Did the Insured have any brothers or sisters ☐ Yes ☐ No

If Yes, please state each name, address and telephone number Use reverse side of this form for additional information

Name of Decedent's Sibling 1	Phone Number of Decedent's Sibling 1
Address of Decedent's Sibling 1	
Name of Decedent's Sibling 2	Phone Number of Decedent's Sibling 2
Address of Decedent's Sibling 2	
Name of Decedent's Sibling 3	Phone Number of Decedent's Sibling 3
Address of Decedent's Sibling 3	

Did the Insured have children ☐ Yes ☐ No

If Yes, please state the name, address and telephone number of each adult child (use additional paper if needed)

MISCELLANEOUS INFORMATION

Was the Insured a U.S. citizen? ☐ Yes ☐ No

Was the Insured's death reported to the U.S. Embassy? ☐ Yes ☐ No

If Yes, please provide a copy of the Death of American Citizen Abroad form. Attached? ☐ Yes ☐ No

SUPPLEMENTAL INFORMATION

Did the insured have a U.S. driver's license ☐ Yes ☐ No	What state?	License #

Initial_____

FOREIGN DEATH QUESTIONNAIRE

SUPPLEMENTAL INFORMATION CONTINUED	
Please provide a color photocopy of the insured's driver's license.	Attached: ☐ Yes ☐ No
Did the insured have a passport? ☐ Yes ☐ No	In what country was it issued?
Please provide the insured's original passport, photocopies are not acceptable. (Passport will be returned to you)	
Attached? ☐ Yes ☐ No	If No Explain:
If the insured was not a U.S. citizen, please provide a copy of their Alien Registration Card, or passport showing United States Visa.	
Attached? ☐ Yes ☐ No	If no, Explain:
Please provide a copy of the insured's Social Security Card.	Attached? ☐ Yes ☐ No
Did the insured file income tax returns in the U.S. during the last two years? ☐ Yes ☐ No	
If No, Explain:	

Please provide a recent color photograph of the insured while living and any photos or videotape of the funeral.

I have read the information provided on the initialed pages, and by my signature declare it is true and correct.

Signature _____ Date _____

Witness _____ Date _____

Initial_____