

# LEADWAY ASSURANCE

## LIFE ASSURANCE CLAIMS FORM



### Death Claim

(A) Name of deceased

(B) Address

(C) Policy number

(D) Deceased's BVN

(E) Date of Death

(F) Place of Death

(G) Age at Death

(H) Cause of Death

(I) Describe the events leading to Death

(J) Occupation at the time of Death

(K) Name and Address of Physician

Please mark the original copy of documents attached for claims verification:

Policy Document	<input type="checkbox"/>
Proof of Age of life assured	<input type="checkbox"/>
Certificate of cause of death <small>(Documents to be returned)</small>	<input type="checkbox"/>
Original proof of Identity	<input type="checkbox"/>
Post Mortem report <small>(where applicable)</small>	<input type="checkbox"/>
BVN Certificate	<input type="checkbox"/>

I declare that the above statement and answers are true and complete in every respect.

Beneficiary Name	Signature
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>