



CLAIM DISCHARGE CS 023

Date Claim received:.....

Appointment Date:.....

INSURED PERSON: _____	TYPE OF CLAIM: _____
³ LIFE INSURED: _____	¹ POLICY No.: _____
DATE OF CLAIM: _____	POLICY PLAN: _____
² TRN (LIFE INSURED): _____	E-MAIL: _____
NATIONALITY: _____	COUNTRY OF CITIZENSHIP: _____
COUNTRY OF BIRTH: _____	TEL. NO.:(W) _____ (H) _____ (Cell) _____
Preferred Methods of Receiving Correspondence: <input type="checkbox"/> E-mail <input type="checkbox"/> Postal mail <input type="checkbox"/> Text message	

POLICYHOLDER/CLAIMANT DATA:

Are you a permanent resident, citizen or national of another country? Yes No If yes, please state: _____

Are you a US citizen, resident or green card holder? Yes No

Taxpayer Identification Number (TIN) (if applicable): _____

Where do you pay taxes? _____

Do you pay taxes in any other jurisdiction? Yes No If yes, please state: _____

Have you recently changed your residential or mailing address? Yes No

If yes, please state new address _____

(Please attach proof of address)

FOREIGN ACCOUNT TAX COMPLIANCE ACT (FATCA) CERTIFICATION

I certify that I the undersigned **am not** a citizen, national, resident, or green card holder of the United States. I further agree to advise Guardian Life Limited as soon as I become aware of any changes that would render this declaration invalid.

I certify that I the undersigned **am** a citizen, national, resident or green card holder of the United States. I further confirm that the Taxpayer Identification Number (TIN) provided above is correct (or I am awaiting a number to be issued to me).

.....
Signature of US / Non-US Customer

.....
Date

Politically Exposed Persons (PEP)/Public Figures:

- Do you, any immediate family or close associates, currently serve or previously served in the capacity of an official/senior official in the administrative, legislative or executive division of the government, military or judiciary of your country of residence or in any other foreign country government? Yes No
- Do you, any immediate family or close associates, currently serve or previously served in the capacity of assistant commissioner or higher of the police force or as a senior executive of a state owned company of your country of residence or a foreign government? Yes No

If you have ticked "Yes" to any of the above, please state the capacity? _____

AUTHORIZATION, DECLARATION AND CONSENT:

I understand that the information provided in this form will enable Guardian Life Limited to manage operations and risks and allow for the enhancement of customer experience. I further comprehend that the information provided may be used to appease information requests of the regulators or in order to satisfy legal or regulatory requirements. I confirm that the information provided is true and correct and can be relied upon by Guardian Life and hereby grant permission for the usage of the information for the purposes herein stated or as may be required from an operational standpoint.

I agree that my client data may be shared within Guardian Life's group corporate structure which includes its parent company, subsidiaries, associated and affiliated companies as well as with credit bureaus and regulators in and outside of the jurisdictions in which Guardian Life operates.

Signature of Insured Person

Date

³ LIFE INSURED: _____ ¹ POLICY No.: _____
² TRN (LIFE INSURED) _____

	FACE VALUE	CLAIM VALUE	BREAKDOWN OF AMOUNT PAYABLE	
Sum Insured	\$ _____	\$ _____	Gross Claim Value	\$ _____
Bonus	\$ _____	\$ _____	Less Policy Loan	\$ _____
Cash Value	\$ _____	\$ _____	A.P.L.	\$ _____
Fund Value	\$ _____	\$ _____	Premium Due	\$ _____
Deposit	\$ _____	\$ _____	Other Charges	\$ _____
AD&D	\$ _____	\$ _____	AMOUNT PAYABLE	\$ _____
GROSS CLAIM VALUE	\$ _____	\$ _____	Add (Ref./Susp.) Interest	\$ _____
			SETTLEMENT VALUE	\$ _____
Equity Value:	_____	Units @ \$ _____		\$ _____

FOR MULTIPLE FUND POLICIES

FUND	AMOUNT AVAILABLE			AMOUNT TO BE ENCASHED	
	Unit Price	No. of Units	\$	(Includes encashment charge if taken from the Fund) No. of Units	\$
Equity	_____	_____	_____	_____	_____
FCI	_____	_____	_____	_____	_____
Money Market	_____	_____	_____	_____	_____
Real Est./LTG	_____	_____	_____	_____	_____
Stabilisation	_____	_____	_____	_____	_____
NStab	_____	_____	_____	_____	_____
Capital Growth	_____	_____	_____	_____	_____
				Total Amount	_____
				Less Surr. Charge	_____
				Less Withhold. Tax	_____
				NET AMOUNT DUE	_____

I am aware that For any Lump Sum Deposit withdrawn less than five (5) years of it being lodged, the Company **is required** to withhold tax at the rate of 25% on all interest earned (subject to existing legislation).

The undersigned request **GUARDIAN LIFE LIMITED** to pay the sum of \$ _____ which amount represents full settlement of the above stated claim under the said policy which is herewith delivered to be cancelled/endorsed. In the absence of the policy contract, please deduct the necessary charges for the replacement.

PAYMENT DETAILS:

Method of payment: Cheque EFT Bank Name _____ Branch _____
 Branch Code _____ Account # _____ Account Type Savings Chequing
 Please make cheque payable to Guardian Life Ltd. for Pol # _____
 Please deliver cheque to: _____
 Signature of: _____
 (Insured Person/Executor/Executrix/Assignee/Beneficiary/Trustee)

MARKSMAN CLAUSE:

This section is to be completed only if the Marksmen Clause applies, that is when a party is unable to read or write by reason of illiteracy, illness or blindness.
 I acknowledge that on payment being made as aforesaid I shall be deemed to have received the above stated sum.

Signed by: _____
 Insert person's full name (Mark is to be placed here)

After the same was read over and explained to him/her and who expressed himself/herself as fully understanding the nature and effects of the contents.

In the presence of

Justice of the Peace _____

Date _____

³ LIFE INSURED: _____ ¹ POLICY No.: _____
² TRN (LIFE INSURED) _____

• CHEQUES WILL BE CANCELLED AFTER ONE MONTH, IF NOT COLLECTED. THE PROCESSING FEE IS NON-REFUNDABLE.

I/WE acknowledge that on payment being made as aforesaid I/WE shall be deemed to have received the above stated sum.

Dated at _____ this _____ day of _____ 20__

NAME OF INSURED PERSON _____

NAME OF WITNESS _____

SIGNATURE OF INSURED PERSON _____

SIGNATURE OF WITNESS _____

ADDRESS _____

ADDRESS _____

NAME OF ASSIGNEE _____

NAME OF WITNESS _____

SIGNATURE OF ASSIGNEE _____

SIGNATURE OF WITNESS _____

ADDRESS _____

ADDRESS _____

NAME OF BENEFICIARY/TRUSTEE _____

NAME OF WITNESS _____

SIGNATURE OF BENEFICIARY/TRUSTEE _____

SIGNATURE OF WITNESS _____

ADDRESS _____

ADDRESS _____

***If not signed at our Offices, this form must be signed in the presence of a Justice of the Peace, Minister of Religion or Attorney-at-Law who is to affix his/her signature & seal or stamp in confirmation of having witnessed the signature.**

***If completed outside of Jamaica, this form must be signed in the presence of a High Commissioner, Jamaican Ambassador, Notary Public, Commissioner of Oaths or Magistrate who is to affix his/her signature & seal or stamp in confirmation of having witnessed the signature.**

FOR INTERNAL USE ONLY:

	<u>Name</u>	<u>Signature</u>	<u>Date</u>
Prepared by
Approved by
Approved by
Cheque No.	Amount (\$)

Index by: Policy Number, TRN, Life Insured Scan all pages of this document.