Death Claim Form

to be completed by the Group Policyholder

ADVANCE Insurance Company of Kansas SM

CLEAR DATA

Section 1 – Benefit Information (All death claims require an original certified copy of the death certificate.)

Applying for death benefits for:

☐ Life ☐ Accidental Death ☐ Dependent Life

$ _____
Amount of Insurance

_____ ____ _____-_____-_____ _____ /_____ /_____
Employee's First Name MI Employee's Social Security Number Date of Employment

_____ ____ _____
Employee's Last Name Suffix Job Title or Occupation

What was the last date this employee physically reported to work and performed their normal job duties? _____ /_____ /_____

What date was this employee last carried on your company's payroll? _____ /_____ /_____

Section 2 – Decedent Information

_____ ____ _____ /_____ /_____ _____ /_____ /_____
Decedent's First Name MI Decedent's Date of Birth Date of Death

_____ ____ _____
Decedent's Last Name Suffix Cause of Death

_____
Decedent's Home Address

Was death due to an accident? ☐ Yes ☐ No

If yes, describe the accident:

_____
City

_____ _____ _____
State ZIP Code +4

Section 3 – Beneficiary Information

_____ ____ _____
Beneficiary's First Name MI Beneficiary's Home Address

_____ ____ _____
Beneficiary's Last Name Suffix City

_____-_____-_____ _____ /_____ /_____ _____ _____ _____ _____
Social Security Number Date of Birth State ZIP Code +4 Relationship to Deceased

_____ ____ _____
Beneficiary's First Name MI Beneficiary's Home Address

_____ ____ _____
Beneficiary's Last Name Suffix City

_____-_____-_____ _____ /_____ /_____ _____ _____ _____ _____
Social Security Number Date of Birth State ZIP Code +4 Relationship to Deceased

Section 4 – Policyholder Information

Remarks: _____

The company will not be held to admit the validity of any claim or to waive the breach of any condition of the policy by furnishing this form or investigating the claim.

_____ _____
Group Policyholder Name Policyholder Address

_____ _____
Title of Employer Representative City

(_____) _____-_____ (_____) _____-_____ _____ _____ _____
Policyholder Phone Number Policyholder Fax Number State ZIP Code +4

Your signature required _____ _____ /_____ /_____
Employer Signature Date Signed

Section 3 – Important Information

The company will not be held to admit the validity of any claim or to waive the breach of any condition of the policy by furnishing this form and investigating the claim.

Warning: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. Report fraud to our Fraud Hotline at 800-530-5989.

Section 4 – Special Instructions

Upon the death of the insured employee or dependent send this claim form, an original certified copy of the death certificate and any other relevant attachments to our claims department at:

Advance Insurance Company of Kansas
1133 SW Topeka Blvd., Topeka, KS 66629-0001
Phone: 785-273-9804 or Toll-free 800-530-5989

The claim form should be fully completed and signed by an authorized representative of the group policyholder. Failure to complete all questions may cause a delay in the claim settlement.

If your plan includes dependent life coverage:

- The beneficiary will be the insured employee if basic dependent coverage.
- The beneficiary of a spouse covered under a voluntary life plan will be as designated.
- The insured parent will be the beneficiary of voluntary life dependent child coverage.

Submit medical proof of death on all death claims in the form of an original **certified copy** of the death certificate.

If death was due to an accident, additional information will be requested and may include one or more of the following in addition to other required documentation:

- Coroner's report
- Police report
- Accident report
- Toxicology report

Self-administered group policyholders should include the original enrollment form and all change of beneficiary forms with the claim form.

If insurance proceeds are payable to the estate of the insured, we will require a copy of the appointment of an administrator or executor of the insured's estate.

If insurance proceeds are payable to a minor child or mentally incompetent person, we will require a copy of the legal documents appointing a conservator for the beneficiary.

If the designated beneficiary is deceased, a copy of his or her death certificate should be furnished with the claim form.

Office Use Only

Claim Number