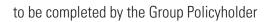
Death Claim Form





Section 1 – Benefit Information	All death claims r	equire a	n origin	al certified co	py of the de	ath certificate.)	
Applying for death benefits for: ☐ Life ☐ Accidental Death ☐ Dependent Life			\$ Amount of Insurance				
Employee's First Name		MI	Employe	e's Social Security	/ Number	Date of Employment	
Employee's Last Name What was the last date this employe	e physically reporte	$\frac{1}{\text{Suffix}}$		or Occupation formed their n	ormal job dut	es?/	
What date was this employee last ca	arried on your comp	any's pay	roll?	//			
Section 2 – Decedent Information	ı						
Decedent's First Name			 Deceder	// nt's Date of Birth		Date of Death	
Decedent's Last Name		Suffix	Cause o	f Death			
Decedent's Home Address			Was death due to an accident?				
City							
State ZIP Code +4							
Section 3 – Beneficiary Informati	on						
Beneficiary's First Name	iciary'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		_ <u>MI</u>	Beneficia	ary's Home Addres	ss		
Beneficiary's Last Name		Suffix	City			_	
Social Security Number	Date of Birth		State	ZIP Code	+4	Relationship to Deceased	
Section 4 – Policyholder Informat	tion						
Remarks:							
The company will not be held the policy by furnishing this fo		-	-	im or to wai	ive the brea	ch of any condition of	
Group Policyholder Name			Policyho	lder Address			
Title of Employer Representative			City				
() Policyholder Phone Number	() Policyholder Fax Nur	mber	State	ZIP Code	+4	_	
Your signature required Employer Signature	gnature					//	

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