

Death Claim Form

for individuals



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

Applying for death benefits for:

Life Child insurance

Policy Number _____ \$ _____
Amount of Insurance

Insured's First Name _____ MI _____ Insured's Social Security Number _____

Insured's Last Name _____ Suffix _____

Section 2 – Decedent Information

Decedent's First Name _____ MI _____ Decedent's Home Address _____

Decedent's Last Name _____ Suffix _____ City _____

Decedent's Date of Birth _____ / _____ / _____ Date of Death _____ / _____ / _____ State _____ ZIP Code _____ +4 _____

Cause of Death _____

Remarks: _____

Section 3 – Beneficiary Information

All beneficiaries must sign and complete the information requested below. If this space is insufficient, please provide the requested information, signed and dated, on a separate piece of paper.

Beneficiary First Name _____ MI _____ Beneficiary Home Address _____

Beneficiary Last Name _____ Suffix _____ City _____

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

Your signature required

Beneficiary Signature _____ Date Signed _____ / _____ / _____

Beneficiary First Name _____ MI _____ Beneficiary Home Address _____

Beneficiary Last Name _____ Suffix _____ City _____

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

Your signature required

Beneficiary Signature _____ Date Signed _____ / _____ / _____

Beneficiary First Name _____ MI _____ Beneficiary Home Address _____

Beneficiary Last Name _____ Suffix _____ City _____

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

Your signature required

Beneficiary Signature _____ Date Signed _____ / _____ / _____

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 (or insured child, if applying for child insurance) send this claim form, a newspaper clipping, a certified copy of the death certificate and the policy, if available, 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. Failure to complete all questions will cause a delay in the claim settlement.

Please be sure to include the Social Security Number, relationship, age and address of each beneficiary. If there is insufficient room on the front of this form, please provide the requested information, signed and dated, on a separate piece of paper.

If your plan includes child insurance coverage:

- Answer questions in Section 2 relating to the deceased as they apply to the child; the beneficiary will be the insured.
- Answer beneficiary questions in Section 3 for Beneficiary A as they apply to the insured.
- The insured should sign and date as Beneficiary A in Section 3.

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

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.

Office Use Only

Claim Number