

Death Claim Form

(to be completed by the Group Policyholder)



For office use only

Claim number

All death claims require an original certified copy of the death certificate.

Benefit being requested:

Life Accidental Death Dependent Life

Amount of insurance \$ _____

Employee's first name _____ MI _____ Last name _____ Suffix _____

Employee's social security no. _____ Date of employment _____ Job title or occupation _____

What was the last date this employee worked the minimum weekly hours required for this benefit? _____

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

The decedent:

Decedent's first name _____ MI _____ Last name _____ Suffix _____

Decedent's home address _____ City _____ State _____ ZIP code _____

Decedent's date of birth _____ Date of death _____ Cause of death _____

Was death due to an accident? Yes No If yes, describe the accident: _____

The beneficiary(ies):

Beneficiary's first name _____ MI _____ Last name _____ Suffix _____

Beneficiary's home address _____ City _____ State _____ ZIP code _____

Beneficiary's relationship to deceased _____ Date of birth _____ Social security number _____

Additional beneficiary's first name _____ MI _____ Last name _____ Suffix _____

Additional beneficiary's home address _____ City _____ State _____ ZIP code _____

Additional beneficiary's relationship to deceased _____ Date of birth _____ Social security number _____

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 and investigating the claim.

Group Policyholder (name) _____ Policyholder phone number _____ Policyholder fax number _____

Policyholder mailing address _____ City _____ State _____ ZIP code _____

Employer sign here _____ Title of person signing _____ Date signed _____

Special instructions

Upon the death of the insured employee or dependent send this claim form, a clipping of the obituary posted in the newspaper, an original certified copy of the death certificate, and any other relevant attachments to the Claims department of:

Advance Insurance Company of Kansas

1133 SW Topeka Blvd.

Topeka, KS 66629-0001

The claim form should be fully completed and signed by an authorized representative of the group policyholder. Failure to complete all the 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 the other required documentation:

- coroner's report,
- police report,
- accident report, and/or
- 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.