

1. Employer's representative complete this side fully. (If claim is for a dependent, have the employee complete the reverse side.)
2. Attach a certified copy of the death certificate.
3. **If the employer holds the employee enrollment card, send a copy with this form.**
4. **Send all to BMA Group Benefits Department.**
5. If the claim is for AD&D benefits, submit a copy of the accident/police report.

PROOF OF DEATH (Group)

MASTER POLICYOWNER'S (EMPLOYER'S) STATEMENT

1. Name of Deceased	Relationship to Employee	Group Policy Number
2. Name of Employee	SS#	Other BMA Policy Nos.
3. Address of Employee <small>(Street Address) (City) (State) (Zip Code)</small>		
4. Deceased's Marital Status, Sex and Birthdate	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Male <input type="checkbox"/> Female	Date Born
5. Effective date of deceased's coverage?	Date, 19	
6. Date deceased's premium paid to?	Date, 19	
7. Amount of deceased's insurance?	\$	

Questions 8 thru 14 refer always to EMPLOYEE.

8.	Name of employer and place where employee worked.	Employer
		Placed Worked
9.	State occupation and describe duties.	Occupation Duties
10.	Was employee terminated? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date, 19
11.	Give hours per week normally worked. Hours
12.	Salary or wages when last worked.	Monthly Weekly Hourly
13.	Did employee cease working before death? Date? If yes, reason.	<input type="checkbox"/> Yes <input type="checkbox"/> No Date, 19
		<input type="checkbox"/> Retired <input type="checkbox"/> Sickness or Injury <input type="checkbox"/> Left voluntarily or discharged
		<input type="checkbox"/> Leave of absence <input type="checkbox"/> Layoff <input type="checkbox"/> Other
14.	If deceased was injured, give date and time. a. Where was deceased when injured? b. Injured on the job? c. How was injury sustained? d. What was extent of injury?	Date, 19 Hour <input type="checkbox"/> AM <input type="checkbox"/> PM
		<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Date and cause of death?	Date, 19 Cause
16.	Beneficiary's name Beneficiary's S.S. # Beneficiary's address Relationship and age	Name
		S.S. #
		Address City State Zip Code
		Relationship Age

The above statement, and accompanying statements, if any, are correct and complete.

Date, 19 By
(Signature) (Title or Position)

BMA is requested to send payment to Beneficiary Master Policyowner for delivery BMA Representative For
Master Policyowner (Employer)

.....
(Street No.) (City) (State) (Zip)

..... /
Area Code (Phone Number)

Employee Statement for Dependent Benefits

Instructions for Insured/Employee:

- a. Complete this side in full.
- b. Attach a certified copy of the death certificate.
- c. Return this form and the death certificate to the employer for submission to BMA.

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1. Name of deceased dependent _____ Relationship to Employee _____
2. Deceased's Marital Status, Sex and Birthdate Married Single Male Female Birthdate _____
3. Effective date of dependent's coverage - Date _____, 19____ Amount of Dependent's Insurance \$ _____
4. Dependents Social Security # _____

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- | | |
|--|--|
| 5. Name of dependent's employer, if any | Employer _____ |
| 6. Address where dependent worked | Address _____ |
| 7. Date last actively at work | Date _____, 19 ____ |
| 8. Had employment ceased before death?
If yes, give date and reason | <input type="checkbox"/> Yes <input type="checkbox"/> No
Date _____, 19____ <input type="checkbox"/> Retired <input type="checkbox"/> Sickness or Injury
<input type="checkbox"/> Layoff <input type="checkbox"/> Left voluntarily or discharged <input type="checkbox"/> Leave of Absence
<input type="checkbox"/> Other _____ |

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- | | |
|---|---|
| 9. Was dependent receiving medical care?
If yes, give name and address of physician. | <input type="checkbox"/> Yes <input type="checkbox"/> No
Name _____
Address _____ |
|---|---|

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- | | |
|--|---|
| 10. Is dependent a full-time student?
If yes, give name and address of school
and number of hours attending. | <input type="checkbox"/> Yes <input type="checkbox"/> No
Name and address _____
Number of hours _____ |
|--|---|

The above statement, and accompanying statements, if any, are correct and complete.

Insured _____ Date _____, 19____
(Signature)

Address _____

Phone Number () _____