



PROOF OF DEATH (Group)

P.O. BOX 419269
KANSAS CITY, MISSOURI 64141
1-800-262-5433 / 753-8000

A member of the Generali Group

- 1. Employer's representative must complete this side fully. (If claim is for a dependent, have the employee complete side 2.)
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 Workplace Benefits.
5. If the claim is for AD&D benefits, submit a copy of the accident/police report.

MASTER POLICYHOLDER'S (EMPLOYER'S) STATEMENT

Form section containing questions 1-7 regarding deceased information, marital status, and insurance details.

Questions 8 thru 14 refer always to EMPLOYEE

Main form section containing questions 8-16 regarding employee details, termination, injury, and beneficiary information.

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

Signature and contact information section including fields for Date, By, Signature, Title, and BMA payment recipient details.

SIDE 2
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.

- 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 _____ Amount of Dependent's Insurance \$ _____
- 4. Dependents Social Security # _____

- | | |
|---|--|
| <ul style="list-style-type: none"> 5. Name of dependent's employer, if any 6. Address where dependent worked 7. Date last actively at work 8. Had employment ceased before death?

If yes, give date and reason | <ul style="list-style-type: none"> Employer _____ Address _____ Date _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ <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 _____ |
|---|--|

- | | |
|---|--|
| <ul style="list-style-type: none"> 9. Was dependent receiving medical care?

If yes, give name and address of physician. | <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No Name _____ Address _____ |
|---|--|

- | | |
|--|--|
| <ul style="list-style-type: none"> 10. Is dependent a full-time student?

If yes, give name and address of school

And number of hours attending. | <ul style="list-style-type: none"> <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 _____
(Signature)

Address _____

Phone Number () _____