

Medical Life Insurance Company
DEATH CLAIM FORM
Group Life Insurance

Return to Medical Life at:
 Attention Claims Department
 1220 Huron Road
 Cleveland, Ohio 44115-1700
 PHONE NUMBER 1-800-782-8533
 Fax: (216) 522-8702

Attach a certified copy of the Death Certificate.

INSTRUCTIONS — ANSWER ALL QUESTIONS FULLY AND SUBMIT ALL NECESSARY ATTACHMENTS TO AVOID UNNECESSARY DELAY AND CORRESPONDENCE

Upon the death of the insured employee or member, complete the claim form as indicated below and send with all attachments to the address above.

Complete the Statement of Policyholder fully and have signed by an authorized officer of the Group Policyholder.

If your group insurance plan includes **Dependent Life Insurance** coverage, use this form to report the death of a dependent as follows:

- 1) answer the shaded boxes as applicable to the dependent;
- 2) answer all other questions in as applicable to the insured employee or member; and
- 3) show the name of the deceased dependent in the "Remarks" section.

Attachments:

You must submit a **certified copy of the official death certificate** together with this claim form.

If death resulted from other than natural causes or if this is a claim for Accidental Death Benefits, attach a **newspaper clipping and/or official report** which give(s) details of the accident.

Self-Administered Groups Only:

In addition to the above requirements, please submit the **original enrollment card** and all applicable **changes of beneficiary**.

If the life insurance benefit is based on salary, please submit **payroll documents which verify the decedent's annual earnings** at the time of death.

STATEMENT OF POLICYHOLDER

Name of Employee		Dependent Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	Job Title/Occupation	Date of Birth
Address				Amt. of Insurance Being Claimed \$ _____ Basic \$ _____ Supp. \$ _____ AD&D \$ _____ Dep. \$ _____
Group No.	Social Security No.	Ins. Class No.	Basic Annual Earnings \$ _____	
Did deceased have Accidental Death & Dismemberment coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are AD&D benefits being claimed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", attach newspaper clipping or police report.		
Did decedent die in a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, was decedent wearing a seat belt? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If the answer to the preceding questions was yes, a copy of the police report must be attached.				
Date of Death	Place of Death	Cause of Death		
If contributory insurance, to what date has employee's contribution been paid?				Date _____
Beneficiary (if estate, certified copy of court order appointing executor or administrator should be attached)				
Name _____		Social Security # _____	Relationship _____	Age _____
Address _____				
If the designated beneficiary is deceased, please furnish a certified copy of his/her death certificate.				
Guardian (If beneficiary is a minor, a certified copy of court order appointing guardian should be attached)				
Full name _____		Address _____		
Date Employed	Date Employment Terminated	Reason for stopping work: <input type="checkbox"/> Resignation <input type="checkbox"/> Retirement <input type="checkbox"/> Illness <input type="checkbox"/> Layoff <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Vacation <input type="checkbox"/> Other (explain briefly)		
Last day of full-time active work for employer		If due to illness, disability benefits were paid: From _____ Through _____ Carrier's Name _____		
Do you recommend payment of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No		Remarks:		
Group Policyholder Name		Address		Telephone No. ()
Mail check to: <input type="checkbox"/> Policyholder at address shown <input type="checkbox"/> Beneficiary at address shown <input type="checkbox"/> Other (please specify in cover letter)				
Completed by (Please type or print)		Signature of Policyholder's Representative/Title		
Date:				

NOTE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.