



CLAIMANT'S STATEMENT

IMPORTANT: Before completing this form, please read instructions on reverse side.

Name of Deceased		Soc. Sec. number	Policy Number
Please list any and all other names by which the insured may have been known, such as maiden name, hyphenated name, nickname, derivative form of first and/or middle name or an alias			
Residence	Street	Town	County State Zip Code
Date of birth	Place of birth	Occupation	
Date of death	Cause of death	Date last worked	
Place of death		Date deceased first consulted a physician for last illness	
If claim for dependent life, give dependent's name		Relationship to employee	
Dependent's marital status <input type="checkbox"/> Married <input type="checkbox"/> Single	Dependent's employment status <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student	Dependent's sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Other life, sickness or accident insurance in force at the time of death. Names of companies and amounts			
If an optional mode of settlement is available and you do not desire payment in one sum, indicate type of settlement desired			

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The undersigned beneficiary(ies) declare(s) that the foregoing statements are true and complete and agree(s) to furnish whatever other information may be required. It is understood that the furnishing of forms by the company does not constitute an admission that there is any insurance in force nor does it constitute an admission of liability.

Date/Signature	Birthdate	Relationship	Soc. Sec. Number	Address	Zip Code
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____



INSTRUCTIONS

This form must be completed by the person or persons to whom the insurance is payable as beneficiary and the employer.

If claim is made by or in behalf of an estate, a minor or an incompetent, a certified copy of the legal appointment must be furnished.

If the principal beneficiary is deceased, a certified copy of the death certificate must be furnished.

A certified copy of the official death certificate will be accepted in lieu of the Attending Physician's Statement if the exact cause of death is shown.

When an official inquiry as to the cause of death has been made, a certified copy of the verdict or findings must be furnished.

When any part of the proceeds is payable to "unnamed children" a statement must be furnished giving the names and dates of birth of each.

The certificate of insurance must accompany this form.

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EMPLOYER'S STATEMENT

Name of employee		Address		Policy number	
<input type="checkbox"/> Married <input type="checkbox"/> Never married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Date of employment		Occupation	
Base annual compensation (exclusive of bonuses, overtime, etc.)				Date of death	
Date last worked		Reason for leaving work <input type="checkbox"/> Disability <input type="checkbox"/> Lay Off <input type="checkbox"/> Dismissed <input type="checkbox"/> Quit <input type="checkbox"/> Leave <input type="checkbox"/> Retired			
Effective date of employee's or dependent's insurance	Certificate number	Amount of insurance	Classification	Date of termination of insurance	
If claim for dependent life, give dependent's name		Dependent's date of birth		Relationship to employee	
Name of beneficiary			Address		
Beneficiary's relationship to deceased			Beneficiary's date of birth		
Date	Signed			Title	
Name of firm	City or town		State	Zip Code	