



LIFE INSURANCE CLAIM

Attn: Life Claims
Post Office Box 2908 • Rancho Cordova, California 95741
1-800-635-5832

Claim For	<input type="checkbox"/> Employee Life and AD&D
	<input type="checkbox"/> Dependent Life
	<input type="checkbox"/> Supplemental Life

Attach certified death certificate. Please see reverse for instructions.

POLICYHOLDER STATEMENT TO BE COMPLETED BY EMPLOYER					
EMPLOYEE NAME LAST	FIRST	MI	EMPLOYEE SSN	EMPLOYEE DOB	
INSURED NAME LAST	FIRST	MI	INSURED SSN	INSURED DOB	
POLICYHOLDER #	POLICYHOLDER NAME				
EMPLOYEE OCCUPATION / JOB TITLE	EMPLOYEE CLASS (If applicable)	BASIC ANNUAL EARNINGS \$	REASON FOR STOPPING WORK (If applicable) <input type="checkbox"/> Resigned <input type="checkbox"/> Illness <input type="checkbox"/> Layoff <input type="checkbox"/> Other _____ <input type="checkbox"/> Retired <input type="checkbox"/> Leave <input type="checkbox"/> Vacation		
EMPLOYEE DATE OF HIRE	EFFECTIVE DATE OF COVERAGE	LAST DATE OF FULL-TIME ACTIVE WORK FOR EMPLOYER		DATE PREMIUMS ARE PAID TO (IF CONTRIBUTORY, DATE TO WHICH CONTRIBUTION HAS BEEN PAID)	
CAUSE OF DEATH (Attach additional sheet, if needed)		DATE OF DEATH		PLACE OF DEATH	
DID DECEASED HAVE ACCIDENTAL DEATH & DISMEMBERMENT COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO			AMOUNT OF INSURANCE CLAIMED		
ARE ACCIDENTAL DEATH BENEFITS BEING CLAIMED? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, ATTACH NEWS CLIPPING OR POLICE REPORT.)			\$	Basic	\$
			\$	AD&D	\$
				Supp	
				Dep	

NAMED BENEFICIARY(IES) STATEMENT TO BE COMPLETED BY EMPLOYER			
NAME OF BENEFICIARY	AGE	SOCIAL SECURITY NUMBER	RELATIONSHIP TO DECEASED
BENEFICIARY'S MAILING ADDRESS			
NAME OF BENEFICIARY	AGE	SOCIAL SECURITY NUMBER	RELATIONSHIP TO DECEASED
BENEFICIARY'S MAILING ADDRESS			
DO YOU RECOMMEND PAYMENT OF THIS CLAIM? <input type="checkbox"/> YES <input type="checkbox"/> NO REMARKS _____			
MAIL CHECK TO <input type="checkbox"/> EMPLOYER AT ADDRESS SHOWN <input type="checkbox"/> BENEFICIARY AT ADDRESS SHOWN <input type="checkbox"/> OTHER (SPECIFY IN COVER LETTER)			
SIGNATURE OF EMPLOYER REPRESENTATIVE X	TITLE OF EMPLOYER REPRESENTATIVE	PHONE # ()	DATE
EMPLOYER ADDRESS STREET	CITY	STATE	ZIP

ATTENDING PHYSICIAN STATEMENT		
If Deceased was disabled more than 31 days prior to death, please have this statement completed by the physician who treated during this disability.		
FULL NAME OF DECEASED	DATE OF DEATH	AGE
PLACE OF DEATH	DATE OF FIRST VISIT	DATE OF LAST VISIT
IMMEDIATE CAUSE OF DEATH	DURATION	
CONTRIBUTORY CAUSES OR COMPLICATIONS	DURATION	
DEATH RESULTED FROM <input type="checkbox"/> Natural Causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		
IF DUE TO ACCIDENT, SUICIDE, OR HOMICIDE, DESCRIBE BRIEFLY		
DECEDENT WAS TOTALLY DISABLED AND UNABLE TO WORK From _____ To _____		
I hereby certify that the above answers are true and complete to the best of my knowledge and belief.		
SIGNATURE X	DATE	
ADDRESS	CITY	STATE ZIP PHONE # ()