

**LIFE, AD&D AND WAIVER OF PREMIUM CLAIM INFORMATION**  
*This form must be completed and submitted by the employer for all claims*

Employer name \_\_\_\_\_ Group policy no. \_\_\_\_\_

Claim is for:  Death  Waiver of Premium  Dismemberment

**EMPLOYEE INFORMATION**

Employee name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Other names previously used \_\_\_\_\_

Home address \_\_\_\_\_  
Street City State Zip

Date of birth \_\_\_\_\_ Date employed \_\_\_\_\_ Date last physically at work \_\_\_\_\_

Identify, if applicable: Employee was:

- Full-time hrs/wk \_\_\_\_\_  Part-time hrs/wk \_\_\_\_\_  
 Owner  Partner  Officer  Other (specify) \_\_\_\_\_  
 Active  On leave of absence  Terminated  Other (specify) \_\_\_\_\_

Occupational duties \_\_\_\_\_

**IDENTIFICATION**

This claim is on  Employee  Employee's spouse  Employee's dependent child

Current beneficiary designation on file with employer \_\_\_\_\_

Current beneficiary address \_\_\_\_\_ Phone No. \_\_\_\_\_  
Street City State Zip

Identification of deceased/injured party (if other than employee):

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Street City State Zip

Date of death \_\_\_\_\_ Date of injury \_\_\_\_\_ Date of disability \_\_\_\_\_

Was claim for permanent disability submitted prior to death?  Yes  No

Amount of insurance in force \$ \_\_\_\_\_

If based on earnings, rate of basic earnings \$ \_\_\_\_\_ Per:  Hour  Week  Month  Annual

**ADDITIONAL INFORMATION**

Was this a work related injury or death?  Yes  No (If yes, include details and a copy of accident report to Workers' Compensation carrier.) \_\_\_\_\_

Any other insurance in force through your firm?  Yes  No (If yes, include amount, name of insurance carrier and policy number.) \_\_\_\_\_

Comments: (Include any information you feel will have any bearing on this claim.) \_\_\_\_\_

Signature of Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

Title of Authorized Representative \_\_\_\_\_



**Completed claim forms should be sent from the employer directly to:**

California Choice Claims Service  
721 S. Parker, Suite 200  
Orange, CA 92868  
(714) 567-4425