

GROUP LIFE CLAIM STATEMENT OF EMPLOYER

1. Name of Deceased: _____
2. Group Policy No.: _____ Certificate Number: _____
- | | |
|-------------------------|----------------|
| 3. Date of Death: _____ | DD / MM / YYYY |
|-------------------------|----------------|
4. Cause of Death: _____
5. Occupation at the time of death: _____
6. Date last at work on a full-time basis: _____
7. Is the employee retired? Yes No
- | | |
|----------------------------------|----------------|
| If so, date of retirement: _____ | DD / MM / YYYY |
|----------------------------------|----------------|
8. Was the employee working the required minimum number of hours per week, to be eligible on this plan, up to his/her recent illness or death? Yes No
9. Current Salary: _____
- *Please note: As outlined in your Group Policy, if the current salary differs from the amount on your last billing statement, we will consider the lesser of the current salary and the billed amount.
10. Was the employee totally disabled from the last date he/she worked until the date of death? Yes No
11. Other: _____

Date: _____ Employer Name: _____

Signature and Title: _____