

IMPORTANT READ CAREFULLY: This form is to be fully completed by the claimant/beneficiary **and** employer and forwarded to QualChoice Life and Health Insurance Company, Inc. (address below). Along with this completed form, submit (1) a certified death certificate, (2) the enrollment application, if available, and (3) any and all change of beneficiary forms executed by the insured. Please forward the life insurance certificate for employee deaths only. **Payroll records are required on all claims.**

NOTE: Only active, full-time employees are eligible for group life insurance products. Part-time or retired employees are not eligible for coverage unless a special provision has been provided for in your group life insurance policy.

IF DEATH RESULTED FROM	PLEASE FURNISH	OTHER	PLEASE FURNISH COPY OF THE FOLLOWING:
other than natural causes	a newspaper clipping (if available)	If your employee is age 65 or older	Current W-2 and 3 months payroll records to certify full time employment
highway accident	highway accident report	If insurance proceeds are payable to insured's estate	Certificate showing appointment of the administrator
homicide	police investigation report & coroner's report	If insurance proceeds are payable to a minor or mentally incompetent person	Certificate showing appointment of a guardian of the estate
		If designated beneficiary is deceased	Certified copy of death certificate

SECTION I. EMPLOYER CERTIFICATION

To be answered in its entirety for all group term claims. If any questions are unanswered, the form will be returned for additional information.

Check appropriate box: <input type="checkbox"/> Group Term Employee Death <input type="checkbox"/> Group Term Dependent Death		Full Name of Employee (LAST, FIRST, MIDDLE INITIAL)												
Employee's Street Address										City/State/Zip				
Full Name of Deceased (if other than employee) (LAST, FIRST, MIDDLE INITIAL)														
Deceased's Street Address										City/State/Zip				
Employee Date of Birth			Gender			Group Number			Certificate Number					
MO	DD	YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female											
Date employee hired full-time			Effective date of coverage			Employee's Job Title			Employee's last full work day			Part-time		
MO	DD	YYYY	MO	DD	YYYY				MO	DD	YYYY	MO	DD	YYYY
Reason for leaving work						Date and amount of last salary change (if life benefits are based on salary)			Hourly Rate		Annual Salary			
<input type="checkbox"/> Resigned <input type="checkbox"/> Retired <input type="checkbox"/> Illness <input type="checkbox"/> Laid Off <input type="checkbox"/> Other (explain): _____						MO DD YYYY			\$ _____		\$ _____			
If employee death - was a claim for disability benefits submitted prior to death			If YES, was the claim for			Was death due to (check one)			Was death due to occupational accident?					
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Waiver of Premium			<input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Accident			<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, enclose copy of Employer's First Report of Injury					
Amount of Benefits Claims			LIFE			AD&D			DEPENDENT LIFE					
\$ _____			\$ _____			\$ _____			\$ _____					
Beneficiary Name (LAST, FIRST, MIDDLE INITIAL)						Beneficiary's Age			Beneficiary's Relationship to Deceased					

I CERTIFY THE ABOVE AS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Name of Company		Street Address		City/State/Zip	
Authorized Company Signature		Official Position		Date	

SECTION II. CLAIMANT/BENEFICIARY CERTIFICATION						
To be answered in its entirety for all group term claims. If any questions are unanswered, the form will be returned for additional information.						
Name of Deceased (LAST, FIRST, MIDDLE INITIAL)					Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Date deceased last worked FULL TIME		Date deceased last worked PART TIME			Reason for cessation of full time work	
MO	DD	YYYY	MO	DD	YYYY	
Your relationship to deceased				Your Age		Your Social Security Number

LIST ALL PHYSICIANS WHO ATTENDED OR PRESCRIBED TO DECEASED IN LAST THREE (3) YEARS:

Physician's Name	Physician's Address
Dates of Attendance	Disease/Condition
Physician's Name	Physician's Address
Dates of Attendance	Disease/Condition

IF HOSPITALIZED IN LAST THREE (3) YEARS, PLEASE LIST THE FOLLOWING:

Hospital Name	Hospital Address	Date Hospitalized	
		FROM	TO
Hospital Name	Hospital Address	Date Hospitalized	
		FROM	TO

SECTION III. COMPLETE THIS SECTION ONLY IF DEPENDENT DEATH CLAIM

How long has the deceased lived in your home?	If death of spouse, indicate if: <input type="checkbox"/> Legally separated <input type="checkbox"/> Divorced – Date of Divorce: _____
Was your spouse/child working? <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, indicate if: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
If death of a child, was he/she a full time student in an accredited school or college? <input type="checkbox"/> YES <input type="checkbox"/> NO	PLACE OF EMPLOYMENT: If YES, for what periods?

SECTION IV. MEDICAL AUTHORIZATION

I, hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical facility, insurance company, governmental agency, Medicare Part A and Part B carrier, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of the above named insured's health, including information relating to mental illness, use of drugs or alcohol, to give QualChoice Life and Health Insurance Company, Inc., or their reinsurers any such information. A copy of this authorization shall be considered as effective and valid as the original.

I CERTIFY THE ABOVE AS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signature of Claimant/Beneficiary	Date	Telephone Number with Area Code
Your Street Address		City/State/Zip