



**PART C: BENEFICIARY INFORMATION**

In order to assure prompt processing, please be certain the authorization below is signed by the beneficiary. The completed and signed claim form along with the Certified Death Certificate, Police Report, Autopsy Report, and any newspaper clippings should be returned to the Employer/Administrator.

NAME OF BENEFICIARY	RELATIONSHIP TO DECEDENT	BENEFICIARY'S DATE OF BIRTH

**NOTE:** If any designated beneficiary is deceased, submit that beneficiary's certified Death Certificate. If the beneficiary is the Deceased's estate, furnish certified letters of Administration or Letters of Testamentary, and Estate Tax ID Number. If the beneficiary is a minor, furnish certified Letters of Guardianship for the minor's estate and minor's social security number.

WHEN DID ACCIDENT HAPPEN? (MONTH, DAY, YEAR)	TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	WHERE DID ACCIDENT HAPPEN? (IF CITY OR TOWN, SHOW STREET NUMBER)
WHAT WAS CAUSE OF DEATH?	DATE OF DEATH (MO., DAY, YEAR) ATTACH COPY OF DEATH CERTIFICATE.	
WHEN DID SYMPTOMS OF CAUSE OF DEATH FIRST APPEAR?		

HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY)

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED DECEASED FOR THE INJURIES CAUSING DEATH.

NAME & ADDRESS	NAME & ADDRESS	NAME & ADDRESS

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED DECEASED DURING THE LAST FIVE YEARS (STATE AILMENTS INVOLVED).

NAME	ADDRESS	AILMENT
NAME	ADDRESS	AILMENT

LIST ALL WITNESSES TO ACCIDENT.

NAME & ADDRESS	NAME & ADDRESS	NAME & ADDRESS

LIST OTHER COVERAGES AND AMOUNTS OF INSURANCE IN FORCE ON DECEASED'S LIFE.

NAME OF COMPANY	POLICY NUMBER	EFFECTIVE DATE	AMOUNT OF INSURANCE
NAME OF COMPANY	POLICY NUMBER	EFFECTIVE DATE	AMOUNT OF INSURANCE

HAVE DIVORCE PROCEEDINGS EVER BEEN INSTITUTED BY OR AGAINST THE DECEASED? IF YES, INDICATE WHEN, WHERE AND THE OUTCOME.

HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

**AUTHORIZATION**

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

**For claimants not residing in California, New York, or Pennsylvania: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

SIGNATURE OF BENEFICIARY, AUTHORIZED REPRESENTATIVE, OR NEXT OF KIN	DATE SIGNED (MONTH, DAY, YEAR)	
ADDRESS OF NEXT OF KIN (NO., STREET, CITY, STATE)	BUSINESS PHONE NUMBER ( )	HOME PHONE NUMBER ( )