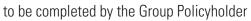
# **Death Claim Form**





Section 1 – Benefit Information (All death claims re	quire a	n original certified copy c	of the death	n certificate.)	
Applying for death benefits for:		\$			
Life Accidental Death Dependent Life		➔ Amount of Insurance			
Employee's First Name	MI	Employee's Social Security Num	nber	Date of Employment	t
Employee's Last Name	Suffix	Job Title or Occupation			
What was the last date this employee physically reported	to worl	< and performed their norma	al job duties	? / /	
What date was this employee last carried on your compa	ny's pay	roll? / /			
Section 2 – Decedent Information					
		// Decedent's Date of Birth		//_	
Decedent's First Name	MI	Decedent's Date of Birth		Date of Death	
Decedent's Last Name	Suffix	Cause of Death			
Decedent's Home Address		Was death due to an ac		□Yes	🗆 No
		If yes, describe the accid	dent:		
City					
State ZIP Code +4					
Section 3 – Beneficiary Information					
· · · · ·					
Beneficiary's First Name	MI	Beneficiary's Home Address			
Beneficiary's Last Name	Suffix	City			
	Jullix	City			
Social Security Number Date of Birth		State ZIP Code	+4	Relationship to Dece	eased
Beneficiary's First Name	MI	Beneficiary's Home Address			
	0	0.1			
Beneficiary's Last Name	Suffix	City			
Social Security Number Date of Birth		State ZIP Code	+4	Relationship to Dece	eased
Section 4 – Policyholder Information					

Remarks: \_\_\_\_\_

The company will not be held to admit the validity of any claim or to waive the breach of any condition of the policy by furnishing this form or investigating the claim.

Group Policyholder Name		Policyholder Address				
Title of Employer Representative		City				
()Policyholder Phone Number	() Policyholder Fax Number	State	ZIP Code	+4	_	
Your signature required					/	/
Emplo	oyer Signature				Date Signed	-
AICK 16 07/23	An independent licensee of the		Page 1			

## Section 3 – Important Information

The company will not be held to admit the validity of any claim or to waive the breach of any condition of the policy by furnishing this form and investigating the claim. **Warning:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. Report fraud to our Fraud Hotline at 800-530-5989.

### Section 4 – Special Instructions

Upon the death of the insured employee or dependent send this claim form, an original certified copy of the death certificate and any other relevant attachments to our claims department at:

#### Advance Insurance Company of Kansas

1133 SW Topeka Blvd., Topeka, KS 66629-0001 Phone: 785-273-9804 or Toll-free 800-530-5989

The claim form should be fully completed and signed by an authorized representative of the group policyholder. Failure to complete all questions may cause a delay in the claim settlement.

If your plan includes dependent life coverage:

- The beneficiary will be the insured employee if basic dependent coverage.
- The beneficiary of a spouse covered under a voluntary life plan will be as designated.
- The insured parent will be the beneficiary of voluntary life dependent child coverage.

Submit medical proof of death on all death claims in the form of an original **certified copy** of the death certificate.

If death was due to an accident, additional information will be requested and may include one or more of the following in addition to other required documentation:

- Coroner's report
- Police report
- Accident report
- Toxicology report

**Self-administered group policyholders** should include the original enrollment form and all change of beneficiary forms with the claim form.

If insurance proceeds are payable to the estate of the insured, we will require a copy of the appointment of an administrator or executor of the insured's estate.

If insurance proceeds are payable to a minor child or mentally incompetent person, we will require a copy of the legal documents appointing a conservator for the beneficiary.

If the designated beneficiary is deceased, a copy of his or her death certificate should be furnished with the claim form.

### **Office Use Only**

Claim Number