

Fort Dearborn Life Insurance Company

DEATH CLAIM FORM

Group Life Insurance

Return to Fort Dearborn at:
 Attention Claims Department
 P.O. Box 655403
 Dallas, TX 75265-5403
 PHONE NUMBER 1-866-628-2606
 Fax: (972) 996-9361

INSTRUCTIONS — ANSWER ALL QUESTIONS FULLY AND SUBMIT ALL NECESSARY ATTACHMENTS TO AVOID UNNECESSARY DELAY AND CORRESPONDENCE

Upon the death of the insured employee, member or insured dependent, the employer must complete the claim form as indicated below and send with all attachments to the address above.

Complete the Statement of Employer fully and have signed by an authorized officer of the Group Policyholder.

Attachments:

You must submit a **certified copy of the official death certificate** together with this claim form.

In addition to the above requirement, please submit the original enrollment card and all applicable **changes of beneficiary**.

If the life insurance benefit is based on salary, please submit **payroll records verifying the employee's annual earnings** at the time of death.

If any portion of the life insurance coverage is contributory, please submit proof of payroll deduction.

STATEMENT OF EMPLOYER

Name of Employee		Name of Decedent	Maiden Name	Alias Name	Dependent Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employee Address			Employee Job Title/Occupation	Decedent's Date of Birth	
Group No. GFZ71778	Employee SS No.	Ins. Class No.	Basic Annual Earnings \$	Amt. Of Insurance Being Claimed	
Did deceased have Accidental Death & Dismemberment Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are AD&D benefits being claimed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", attach newspaper clipping and police report.		\$ _____ Basic	
Did decedent die in a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, was decedent wearing a seat belt? <input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____ Supplemental	
If the answer to the preceding question was yes, a copy of the police report must be attached.				\$ _____ AD&D	
				\$ _____ Voluntary	
				\$ _____ Dep.	
				\$ _____ Other	
Date of Death	Place of Death	Cause of Death			
If contributory insurance, to what date has the employee's contribution been paid? Date _____					
Beneficiary (if estate, certified copy of court order appointing executor or administrator should be attached)					
Name _____		Social Security No. _____		Relationship _____ Age _____	
Address _____				Phone No. () _____	
If the designated beneficiary is deceased, please furnish a certified copy of his/her death certificate.					
Guardian (If beneficiary is a minor, a certified copy of the court order appointing guardian of minor's estate should be attached)					
Full name _____		Address _____			
Date Employed	Date Employment Terminated	Reason for stopping work: <input type="checkbox"/> Resignation <input type="checkbox"/> Retirement <input type="checkbox"/> Illness <input type="checkbox"/> Layoff <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Vacation <input type="checkbox"/> Other (explain briefly)			
Employee's last day of full-time, active work for employer.		If due to illness/injury, disability benefits were paid: From _____ Through _____ Carrier's Name _____			
Do you recommend payment of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No		Remarks:			
Group Policyholder Name			Telephone No. ()	Fax No. ()	
Street Address		City	State	Zip	
Completed by (Please type or print)		Signature of Policyholder's Representative/Title			Date

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.