



GROUP LIFE INSURANCE CLAIM

Associated
MUTUAL INSURANCE

3809 Lake Eastbrook Blvd SE, Grand Rapids, MI 49546
Phone: (800) 370-4349 Fax: (616) 808-2899 options@associatedmutual.org

By furnishing this blank and investigating the claim, the Company shall not be held to admit the validity of any claim or to waive the breach of any condition of the Policy.

If death of insured employee or member, THIS CLAIM FORM COMPLETED AND SIGNED BY EMPLOYER OR PLAN ADMINISTRATOR and the CERTIFIED DEATH CERTIFICATE should be sent to:

.....Associated Mutual -gi fUbWZ-bW
, \$- @_Y9UgHfcc_6`j X'G9, Grand Rapids, Michigan 49546

If death resulted from other than natural causes, newspaper clippings, police or official reports, etc., should be furnished whenever possible.

INSURED INFORMATION				
Social Sec. No.		Name of Insured Employee		Basic Annual Earnings
Occupation		Duties		
Insurance Terminated Prior to Death? (If Yes, Give Date and Reason)			Date Terminated	Reason Terminated (Resigned, Discharged, Retired or other (Specify))
Amount of Life Insurance		Date Employed		Date Last Worked Full Time
Life	Accidental Death			Mo. Day Yr. Hour AM/PM
\$	\$			
SELF-ADMINISTERED GROUP POLICYHOLDERS should attach the original enrollment card and all Beneficiary Change Forms				

DECEASED INFORMATION				
Name of Deceased		Address - Street		City State
Relation	Birth Date MO/DY/YR	Date of Death MO/DY/YR	Place of Death	Cause of Death
Occupation Accident <input type="checkbox"/> Worker's Compensation Report Attached		Accidental Death - Proof Attachments <input type="checkbox"/> Official Reports <input type="checkbox"/> Newspaper Clippings <input type="checkbox"/> Other		

BENEFICIARY INFORMATION				
If insurance proceeds are payable to: - estate of insured, a certificate of appointment of administrator or executor should be furnished. - minor or mentally incompetent, a certificate of appointment of legal guardian should be furnished. If designated beneficiary is deceased, a certified copy of the death certificate should be furnished.				
1. Name		Soc. Sec. No.	Age	Relationship
Address - Street		City	State	Zip
2. Name		Soc. Sec. No.	Age	Relationship
Address - Street		City	State	Zip
3. Name		Soc. Sec. No.	Age	Relationship
Address - Street		City	State	Zip

EMPLOYER				
Do you recommend payment of claim? <input type="checkbox"/> Yes <input type="checkbox"/> No Remarks -				
Employer				
Date	By	Title	Phone	
Address				

LIFE INSURANCE CLAIM PHYSICIAN'S STATEMENT

(To be furnished without expense to the Company if death certificate is not available)

In the interest of accurate vital statistics, please conform to the International List of Causes of Death.

Full Name of Deceased		Residence at Death
Age at Death or Date of Birth	Date of Death	Place of Death (If Hospital or Institution, Give Name)

CAUSE OF DEATH (Enter only one cause for each of a, b, and c)	INTERVAL BETWEEN ONSET AND DEATH
Disease or condition directly leading to death: (This does not mean the mode of dying, such as heart failure, asthenia, etc. It means disease, injury or complication which caused death) (a)	(a)
Antecedent Causes (Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last) Due to (b) Due to (c)	(b) (c)
Other significant conditions: (Contributing to the death but not related to the disease or condition causing death)	

DATE OF FIRST ATTENDANCE IN LAST ILLNESS	DATE OF LAST ATTENDANCE IN LAST ILLNESS
If death was due to accident, suicide or homicide, specify which. Describe briefly.	Was an inquest held? <input type="checkbox"/> Yes <input type="checkbox"/> No Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, by whom and with what findings? <input type="checkbox"/> Yes <input type="checkbox"/> No

Have you treated or advised the deceased during the last 5 years, prior to the last illness? Yes No

Did the deceased, to your knowledge, receive treatment during the last 5 years from any other physician, or in any Hospital or Institution? Yes No

IF YES TO EITHER QUESTION, PLEASE FURNISH THE FOLLOWING:

NAME OF PHYSICIAN OR INSTITUTION	ADDRESS	NATURE OF ILLNESS OR INJURY	DATES

These statements are true and complete to the best of my knowledge and belief.

	Signature		M.D.
Date	Address		Phone