QualChoice® HEALTH INSURANCE

Group Life Insurance Claim Form

Underwritten by QualChoice Life and Health Insurance Company, Inc.

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 than natural causes	a newspaper clipping (if available)
highway accident	highway accident report
homicide	police investigation report and coroner's report

Other	Please furnish copy of the following:
If your employee is age 65 or older	Current W-2 **and** 3 months payroll records to certify full-time employment
If insurance proceeds are payable to insured's estate	Certificate showing appointment of the administrator
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:
☐ Group Term Employee Death ☐ 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 ☐ Male ☐ Female | Group Number | Certificate Number

Date employee hired full-time | Effective date of coverage | Employee's Job Title | Employee's last full work day | Part-time

Reason for leaving work
☐ Resigned ☐ Retired ☐ Illness ☐ Laid Off
☐ Other (explain): _____

Date and amount of last salary change (if life benefits are based on salary)
Date | Hourly Rate $ | Annual Salary $

If employee death, was a claim for disability benefits submitted prior to death? ☐ Yes ☐ No

If YES, was the claim for
☐ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium

Was death due to (check one)?
☐ Natural ☐ Homicide ☐ Suicide ☐ Accident

Was death due to occupational accident?
☐ Yes ☐ 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

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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 ☐ Male ☐ Female
Date deceased last worked FULL-TIME	Date deceased last worked PART-TIME	Reason for cessation of full time work	
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: ☐ Legally separated ☐ Divorced Date of Divorce: _____
Was your spouse/child working? ☐ Yes ☐ No	If YES, indicate if: ☐ Full-time ☐ Part-time	Place of Employment:
If death of a child, was he/she a full time student in an accredited school or college? ☐ Yes ☐ No		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

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