

LIFE INSURANCE CLAIM FORM

Claimant's Statement

(Before completing, read Instructions on back of this form)



PROOF OF DEATH (please attach policy and death certificate)

American Community policies

Policy Number	Effective Date	Amount of Coverage
_____	_____	_____
_____	_____	_____
_____	_____	_____

Deceased's name in full _____

Maiden name _____ Nickname _____

Hyphenated name _____ Alias _____

Derivative form of first and/or middle name _____

Address: _____
(street) (city) (state) (zip code)

Date of birth: _____ Place of birth: _____

Occupation at death: _____ Date last worked: _____

Date of death: _____ Place of death: _____

Cause of death: _____

Names and addresses of all physicians who treated deceased for last illness:

Names	Address	First treatment date	Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Life Insurance

Name of the Company	Address	Amount of Coverage
_____	_____	_____

I (We), claim the benefit payable under the Policies listed above and agree that the written statements and affidavits of all the physicians who attended or treated the insured, and all other papers called for by instructions for completing this claim form, shall constitute a part of this form. I (we) further agree that receipt of this form by American Community Mutual Insurance Company shall not constitute nor be considered an admission by it that there was any insurance on the life in question, nor any waiver of any of its rights or defenses.

Dated at _____ this _____ day of _____ year _____
(city) (state)

Claimant's signature _____ **Relationship to deceased:** _____

Claimant's name (please print) _____ Date of birth: _____ S.S. # _____

Address: _____
(street) (city) (state) (zip code)

Witnesses' signature _____ **Witnesses' name (please print)** _____

Dated at _____ this _____ day of _____ year _____
(city) (state)

Claimant's signature _____ **Relationship to deceased:** _____

Claimant's name (please print) _____ Date of birth: _____ S.S. # _____

Address: _____
(street) (city) (state) (zip code)

Witnesses' signature _____ **Witnesses' name (please print)** _____

Dated at _____ this _____ day of _____ year _____
(city) (state)

Claimant's signature _____ **Relationship to deceased:** _____

Claimant's name (please print) _____ Date of birth: _____ S.S. # _____

Address: _____
(street) (city) (state) (zip code)

Witnesses' signature _____ **Witnesses' name (please print)** _____

Instructions

A Claimant's Statement must be executed before a witness by the person or persons to whom the insurance is payable. In connection with such statement, the following should be observed:

- (1) If there is more than one beneficiary, all may join in one statement or a separate form will be furnished for each person if desired.
- (2) If the policy is payable to the estate or to the executors or administrators of the insured, the statement should be executed by the executor or administrator and a certificate of appointment and qualifications must be furnished.
- (3) If the policy is payable to a minor or a mentally incompetent person, the statement should be executed by a guardian and a certificate of appointment and qualifications must be furnished.

A Death Certificate is necessary in all cases. We accept copies but reserve the right to request a certified copy. Newspaper clippings relating to the death or burial should be sent if possible, especially in cases of accidental death or questionable deaths.

A death certificate of any deceased beneficiary should be furnished.

If the name of the beneficiary has changed due to marriage or divorce, please send a copy of the legal document showing the name change.

Notice: Any person, who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

TO BE COMPLETED BY THE EMPLOYER

(for group policies only)

Name of Employee: _____ Date of Birth: _____

Address: _____
(street) (city) (state) (zip code)

Policy number: _____ Certificate Number: _____

Amount of Insurance: Basic Life \$ _____ AD&D \$ _____

Date of hire: _____ Date on which employee last worked: _____

Date employment terminated: _____ Reason for termination: _____

Date of death: _____ Place of death: _____

Cause of death: _____

Was death due to occupation? _____ If yes, please give details: _____

Name of Beneficiary: _____ Relationship: _____

Name & address of Employer: _____

Telephone number: _____

Date: _____ Completed by: _____ Title: _____