FORT DEARBORN LIFE
Insurance Company

Death Claim Form - Group Life Insurance

Return to Fort Dearborn Life at:
Attention Claims Department
P.O. Box 655403
Dallas, Texas 75265-5403

Phone Number: 1 (800) 778-2281
Fax: 1 (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? ☐ Yes ☐ No

Employee Address	Employee Job Title/Occupation	Decedent's Date of Birth

Group No.	Employee SS No.	Ins. Class No.	Basic Annual Earnings $

Did deceased have Accidental Death & Dismemberment Coverage? ☐ Yes ☐ No

Are AD&D benefits being claimed? ☐ Yes ☐ No
If "yes", attach newspaper clipping and police report.

Did decedent die in a motor vehicle accident? ☐ Yes ☐ No
If yes, was decedent wearing a seat belt? ☐ Yes ☐ No
If the answer to the preceding question was yes, a copy of the **police report must be attached.**

Amt. Of Insurance Being Claimed
$ _____ Basic
$ _____ Supplemental
$ _____ 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: ☐ Resignation ☐ Retirement ☐ Illness ☐ Layoff ☐ Leave of Absence ☐ Vacation ☐ 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? ☐ Yes ☐ 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.