

# 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:** For your protection, Arizona law requires the following statement to appear on this form. Any person, who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

### 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: \_\_\_\_\_



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