Life applicant statement
Death Claim

TO EXPEDITE THE PROCESS OF YOUR CLAIM, REMEMBER:

- **Each beneficiary must complete the life applicant statement – Death Claim.**
- **See the necessary documents to establish the death claim on the back, as applicable.**
- **Send via email to: segurodevidacommercial@medicalcardsystem.com**

NAME OF DECEASED		NAME OF PRIMARY POLICYHOLDER
DATE OF BIRTH	DATE OF DEATH	POLICY NUMBER
PLACE OF BIRTH		PLACE OF DEATH OR HOSPITAL (IF APPLICABLE)

***** ANTI-FRAUD NOTICE*****

"Any person who knowingly and with intent to defraud presents false information in an insurance application or who presents, assists, or causes to present a fraudulent claim for payment of a loss or other benefit, or presents more than one claim for the same damage or loss, commits a felony and, upon conviction, shall be punished for each violation with a fine of not less than five thousand (5,000.00) dollars nor more than ten thousand (10,000.00) dollars or imprisonment for a fixed term of three (3) years, or both penalties. If aggravating circumstances exist, the fixed penalty may be increased up to a maximum of five (5) years; if mitigating circumstances exist, it may be reduced to a minimum of two (2) years."

CAUSE OF DEATH
DATE THE DECEASED FIRST BECAME ILL WITH THE CONDITION OR CAUSE OF DEATH
DATE FIRST CONSULTED A DOCTOR FOR THIS ILLNESS
DATE LAST WORKED OR ATTENDED WORK

PHYSICIANS WHO VISITED OR ATTENDED THE DECEASED DURING THE LAST FIVE YEARS BEFORE DEATH (STARTING WITH THE MOST RECENT)

NAME	ADDRESS	ILLNESS TREATED	DATE OF TREATMENT

LIST OTHER ACTIVE LIFE OR ACCIDENT INSURANCE POLICIES OF THE DECEASED

INSURANCE COMPANY	POLICY DATE	AMOUNT

A MCS LIFE INSURANCE COMPANY DECLARACIÓN

The undersigned hereby claims to be the beneficiary or one of the beneficiaries of the mentioned insurance and agrees that the written statements and affidavits of all physicians who attended and treated the insured and all other requested documents, as stated above, shall constitute and henceforth be part of the "Proof of Death." Furthermore, the undersigned accepts that the delivery by MCS LIFE INSURANCE COMPANY of this form or any other supplementing it shall not constitute nor be considered as an admission that there was in force an insurance policy on the life of the deceased, nor that it waives any of its rights or defenses. I expressly waive, on my own behalf and on behalf of any other party that may have or claim interest in any policy issued to the insured, all provisions of law prohibiting any physician or any other person who attended or examined the insured, or any hospital (including the Veterans Hospital) or sanatorium in which the insured was confined, treated, or examined, from disclosing information or knowledge acquired in this regard and authorize the provision of all such information to the above-mentioned insurance company. A photostatic copy of this authorization shall be considered as valid as the original.

CLAIMANT'S NAME _____ AGE _____ RELATIONSHIP _____

MAILING ADDRESS _____

CLAIMANT'S SIGNATURE _____ PHONE NUMBER (____) _____

Documents required to establish a death/funeral claim

1. Complete the Form of Death/Funeral Claim
2. Death Certificate
3. Funeral home invoice
4. Evidence of expenses incurred and paid