MCS Life

Life Insurance Group
Proof of Loss of Life and Accidental Death Insurance

*****FRAUD NOTICE*****

Any person who knowingly and with intent to defraud presents false information in an insurance application or who submits, assists, or causes to submit a fraudulent claim for payment of a loss or other benefit, or submits 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.

INSTRUCTIONS

This form is for life insurance or accidental death proceeds only. This claim will be subject to delay or return if these instructions are not followed.

To the employer-administrator:

• Attach the registration or beneficiary designation form • Submit newspaper clippings, if available • Submit the completed form to the Claims officer assigned along with the Death Certificate stating the cause of death • Declaration of Heirs (if applicable) • Certified copy of Marriage Certificate (if applicable), Certified copy of the beneficiary's Birth Certificate • Certified copy of the Social Security card of the beneficiary and the guardian (if applicable) • Proof of payment of Funeral Expenses (optional) • Police report (in case of death not from natural causes) • Autopsy report (in case the cause of death is not determined) • A separate form must be completed for each beneficiary.

Name of employee (Last name) (First name) (Initial)	Contract number	Date of Birth (mm/dd/year) ____/____/_____	Sex ( )Male ( ) Female
Address (Street) (City) (State) (Zip code)			
Policy number (s) (including AD & D policy no. if different)		Occupation	Alternate phone number
Please check the appropriate blocks regarding the insured's employment status ( )Active ( )Exempt ( )Management ( )Supervisory ( )Union Local #_____ ( )Full Time ( )Salaried ( )Retirer ( )Non-Exempt ( )Non-Management ( )Non-Supervisory ( )Non-Union ( )Part Time ( )Hourly			Hours / Work. #_____
Amount in of insurance Basic: _____ Supp: _____ AD&D: _____	Date of last increase in benefits	Date of last Change in Income	Basic Annual Income
Effective Date of Insurance	Premium Paid Thorough Date	Date of hired/Member of Association	Last date worked
Was coverage still in effect through date of death? If not, please explain.	Was the above considered an employee/Association member until date of death? If not, please explain.		

Please complete this section if the claim is for dependent benefits

Name of dependent (Last name) (First name) (Initial)	Alternate phone number	Date of Birth	Sex ( ) Male ( ) Female
Amount of dependent insurance	Relationship to the employee/Association Member	Dependent's occupation	
If child ( ) Full-Time student ( ) Part-Time student	Name and address of school		

Please complete this section if the claim is for accidental death benefits

Where and how did the accident happen? Please describe in detail	
Date and time of accident	What diseases, illnesses, or injuries did the deceased have during the past three (3) years?

Beneficiary information

Name of beneficiary (Last name) (First name) (Initial)	Social Security: _____ - _____ - _____	Date of birth	Sex ( ) Male ( ) Female
Current mailing address (Street) (City) (State) (Zip code)			
Relationship with the deceased		Email	Age

Please complete this section if the beneficiary is a minor

Name of legal guardian (Last name) (First name) (Initial)	Phone number	Email address
Physical address (Street) (City) (State) (Zip code)	Current mailing address (Street) (City) (State) (Zip code)	

Employer's/Administrator's certification

Name of employer		Division
Address (Street) (City) (State) (Zip code)		Phone number

This is to certify that the facts as indicated above are true to the best of my knowledge and belief.

Signature of authorized representative	Title	Date signed

The issuance of this blank is not an admission of the existence of any insurance nor does it recognize the validity of any claim and without prejudice to the company's legal rights in the premises.