MCS Life

Life Insurance Group

Proof of Loss of Life and Accidental Death Insurance

Any person who is knowingly and with intent to defraud any insurance company or other person files a statement containing materially false information or conceal for the purpose of deceiving of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

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 beneficiary form • Please submit newspaper clips, if available • Submit completed form to the assigned Claims Officer with a Death Certificate.

Name of Employee (Last Name) (First Name) (Initial)	Alternate Phone Number	Date of Birth	Sex ( )Male ( ) Female
Address (Street) (City) (State) (Zip Code)			
Policy number (s) (including AD & D policy no. if different)		Occupation	
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 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 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 3 years?

Beneficiary Information

Name of Beneficiary (Last Name) (First Name) (Initial)	Social Security (last 4 digits) XXX - XX - _____	Date of Birth	Sex ( ) Male ( ) Female
Address during past month (Street) (City) (State) (Zip code)			
Relationship with the deceased			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)	Postal 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	Tittle	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.