THE LAFAYETTE LIFE INSURANCE COMPANY
1905 TEAL ROAD
POST OFFICE BOX 7007
LAFAYETTE, IN 47903
(765) 477-7411 FAX (765) 477-3236

GROUP LIFE INSURANCE - DEATH CLAIM REPORT

YOU MAY CALL THE CLAIMS DEPARTMENT TOLL FREE AT 1-800-243-6631 WITH ANY QUESTIONS

THIS FORM MUST BE COMPLETED AND SIGNED BY THE POLICYHOLDER (EMPLOYER, ASSOCIATION, ETC.), NOT BY THE DESIGNATED BENEFICIARY. SEE SPECIAL INSTRUCTIONS ON THE REVERSE SIDE OF THIS FORM.

Name of Employee (Member) | Group Policy No. | Certificate No.

Is this claim for (check application box)

☐ Employee ☐ Dependent
Deceased:
Name of Deceased/Dependent _____
Date of Birth _____
Social Security No. _____
Date of Death _____
Residence _____
City _____ State _____ Zip _____

Was Evidence of Insurability required for Employee or the Dependent?
☐ Employee ☐ Dependent
☐ Yes ☐ No

Life amount applied for?
☐ Basic $ _____
☐ Optional $ _____
☐ Supplemental $ _____

To what date were premiums last paid on deceased? _____

Is Insurance Based on Employee's Salary?
☐ Yes ☐ No
What is salary amount? _____
What is date of last salary increase? _____
How is life amount calculated? _____

What is Employee's insurance classification? _____
When was the last change date? _____
What is Employee's job duties? _____

What is reason Employee left work before death?
☐ Disability, when did it begin? _____
☐ Retirement, when did it take effect? _____
☐ Vacation, when did it begin? _____
☐ Other Date? _____ Explain _____

(If claim is for an Employee)
What is the date the Employee last physically worked for policyholder/employer? _____

(If claim is for an Employee)
Was deceased considered to be an Employee on date of death?
☐ Yes ☐ No ☐ Why not? _____

Beneficiary: Please print each beneficiary's full name, complete address, date of birth, Social Security Number and relationship to deceased.
Name _____
Address _____
City _____ State _____ Zip _____
DOB _____ Relationship _____
Social Security Number _____

Name _____
Address _____
City _____ State _____ Zip _____
DOB _____ Relationship _____
Social Security Number _____

Is a claim being made for the Accidental Death Benefit?
☐ Yes ☐ No
☐ Basic $ _____
☐ Optional $ _____
☐ Supplemental $ _____

If Policyholder is an Association or Union, was deceased a member in good standing at time policy was issued?
☐ Yes ☐ No

Was deceased a member in good standing at time of death?
☐ Yes ☐ No
If not, why not? _____

Date to which dues and assessments paid in full. _____

Please provide the name and address to which this claim check should be sent. _____

THE ABOVE AND FOREGOING STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Policyholder (Print) _____ Telephone No. (Please include area code) _____

X _____ Title _____ Date _____
Signature of Authorized Representative

Indiana Law requires this notice to appear on this form -

A person who knowingly, and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

- ATTACH CERTIFICATE OF DEATH -
OR HAVE PHYSICIAN'S CERTIFICATE COMPLETED ON REVERSE SIDE