

IMPORTANT: READ CAREFULLY

This form should be completed by the claimant and by the employer upon the death of an insured employee or insured dependent and should be forwarded to Regence Life and Health Insurance Company with an original certified death certificate and the enrollment card(s). **IF DEATH WAS DUE TO SUICIDE, HOMICIDE OR ACCIDENTAL MEANS, IT WILL BE NECESSARY TO FURNISH A CORONER'S REPORT AND A COPY OF INVESTIGATING OFFICER'S REPORT.** By furnishing this form and investigating the claim, the Company shall not be held to admit the validity of any claim or to waive or breach any condition of the policy.

CLAIMANT'S STATEMENT

NAME OF DECEASED		SOCIAL SECURITY NUMBER	DATE OF BIRTH	DATE OF DEATH
When did health of deceased first become impaired?	In last illness, when did deceased first consult physician?		Date deceased last attended full time work	
PLACE OF DEATH			If hospital or institution confined, date of confinement	
List primary care physician and any other physician who attended deceased immediately preceding death.				
NAME AND ADDRESS		TREATMENT DATES	CONDITION(S)	
		FROM THROUGH		
		FROM THROUGH		
CLAIMANT ADDRESS (Street, City, State, Zip)			TELEPHONE NO. ()	
CLAIMANT'S SIGNATURE (Required) ▶		DATE	AGE	RELATIONSHIP TO DECEASED

INSURANCE FRAUD WARNING - Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

EMPLOYER'S STATEMENT

EMPLOYER NAME		GROUP NUMBER	EMPLOYER TELEPHONE NO. ()
MAILING ADDRESS (Street, City State, Zip)			
EMPLOYEE NAME		SS NUMBER	DATE EMPLOYED
EMPLOYEE ADDRESS (Street, City, State, Zip)			
CLAIM IS FOR <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT CHILD		AMOUNT OF INSURANCE \$	
DATE DECEASED LAST PHYSICALLY ATTENDED WORK	REASON CEASED FULL-TIME EMPLOYMENT ON THIS DATE (death, disabled, laid off, etc.) <input type="checkbox"/> Death <input type="checkbox"/> Disabled <input type="checkbox"/> Lay-Off <input type="checkbox"/> Retired <input type="checkbox"/> Other (explain)		
IF CLAIM IS FOR DISABLED EMPLOYEE, WAS A CLAIM FOR TOTAL DISABILITY SUBMITTED PRIOR TO DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU RECOMMEND PAYMENT OF THIS CLAIM? <input type="checkbox"/> YES <input type="checkbox"/> NO (explain)		
FOR CLAIM ON DEPENDENT NAME OF DECEASED DEPENDENT		RELATIONSHIP TO EMPLOYEE	DEPENDENT DATE OF BIRTH
BENEFICIARY NAME		BENEFICIARY DATE OF BIRTH	BENEFICIARY SS NUMBER
BENEFICIARY ADDRESS (or contact if beneficiary is a minor) (Street, City, State, Zip)		BENEFICIARY PHONE (or guardian if beneficiary is a minor) ()	
REMARKS			
COMPLETED BY (please print) TITLE		SIGNATURE (Required)	DATE