

Death Claim Form-Group Life Insurance

NATIONAL EMPLOYEES
HEALTH PLAN

PLEASE ANSWER ALL QUESTIONS FULLY
ATTACH A CERTIFIED COPY OF DEATH CERTIFICATE

Policy Identification: This information must be completed to identify coverage

Name of Employer: _____

Address: _____

Name of Employee: _____

Employee's Participant ID: _____ Effective Date of Insurance: _____

Job Position: _____

Date Employed: _____ Date Last Worked: _____

Enrolled Coverage: Life AD&D Amount of Insurance on Deceased: _____

Full Name of Deceased: _____

Deceased date of Birth: _____ Claim is For: Employee Spouse Child

Residential Address of Deceased: _____

Deceased Participant ID: _____ Date of Death: _____

Cause of Death: _____

Manner of Death: Natural Accident Suicide Homicide

If other than natural causes, provide details and police report if applicable: _____

Was deceased considered an employee on date of death: Yes No

Name of Beneficiaries

Name	Relationship	Age	Address
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Authorization

The statements above are true and complete. I/we agree that National Employees Health Plan may rely on them as part of the Proofs of Death.

Printed name of applicant

Signature of applicant / Date