MEDICO®
LIFE AND HEALTH INSURANCE COMPANY

P.O. Box 10386
Des Moines, IA 50306-0386
Toll Free 1-800-228-6080

STATEMENT OF DEATH (GROUP LIFE INSURANCE CLAIM FORM)
EMPLOYER'S STATEMENT

This form should be completed by the employer upon the death of an insured employee and should be forwarded to above address. By furnishing this form and investigating the claim, the insurance company shall not be held to admit the validity of any claim or to waive or breach any condition of the policy.

EMPLOYER'S STATEMENT

1. Name of Employer | Group No.

2. Address

3. Name of Deceased Employee | Social Security No. | Date of Birth

4. Date Employed | Date on which insured last worked full-time

5. Reason for ceasing full-time employment on this date (death, disabled, laid off, etc.)

6. Date on which premium payment ceased | Amount of Insurance

7. Date of Death | Place of Death

8. Cause of Death | Was death due to accident? ☐ Yes ☐ No

9. Name of Beneficiary | Relationship

If available, please include copy of last recorded beneficiary.

10. Age of Beneficiary, if minor | Address of Beneficiary

11. Remarks:

Name of authorized individual (Type or Print) _____

Title or Position _____ Telephone _____

Signature _____ Date _____
Month Day Year

Any person who knowingly and with Intent to defraud or deceive an insurance company, files a statement of claim containing false, incomplete or misleading information, is in some states guilty of a felony.