MEDICO®
LIFE AND HEALTH INSURANCE COMPANY

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

# PROOF OF DEATH

## DEATH OF AN INSURED DEPENDENT

**Important: Read Carefully**

**WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a claim for insurance may be guilty of a crime and subject to fines and confinement in prison.**

**This form is to be completed upon the death of an insured and forwarded to Medico Life and Health Insurance Company. In addition, a certified copy of the original death certificate is required. If death was due to suicide, homicide or accidental means, a copy of the investigating officer's report is also required. By furnishing this form and investigating the claim, Medico Life and Health Insurance Company shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.**

### EMPLOYER'S STATEMENT

| | | |
|---|---|---|
| Group Number | Certificate/ ID Number | |
| Name of Employee | Date Employed | Date Last Worked |
| Name of Deceased Dependent | Date of Death | |
| Employer | Date | |
| Signature | Title | |
| Name (please print or type) | Telephone ( ) | |
| Address | City, State, Zip | |

### EMPLOYEE'S STATEMENT

| | | |
|---|---|---|
| Deceased's Relationship to Employee<br>☐ Spouse ☐ Child | Deceased's Date of Birth | Cause of Death |

If relationship is shown to be "child," was deceased married at the time of death? ☐ Yes ☐ No

If relationship is shown to be "spouse," was deceased married at the time of death? ☐ Yes ☐ No

Was the deceased a dependent and used by you as such for income tax purposes? ☐ Yes ☐ No

Do you want dependent coverage cancelled? ☐ Yes ☐ No

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to the deceased which may have a bearing on the benefits payable under this or any other plan providing benefits or services.

I certify that the information furnished in support of this claim is try and correct.

Date_____ Employee's Signature_____ Employee's Social Security # _____

Address_____ City, State, Zip_____ Daytime Telephone_____