



GROUP LIFE BENEFITS DEPARTMENT
LIFE CLAIM REPORT

Return to:

Great-West Healthcare
Group Life and Disability
8525 East Orchard Road, 5T3
Greenwood Village, CO 80111
Telephone Number: 1-800-537-2033

PART I EMPLOYER'S OR ADMINISTRATOR'S STATEMENT

Name of Deceased _____ SS No. _____ Group Policy No: _____

Address _____
Street City State

If dependent claim, provide name of employee and relation to deceased _____

Amount of Life Insurance Benefit \$ _____ Amount of Optional Life Insurance Benefit \$ _____

Amount of the Accidental Death Benefit (If Applicable) \$ _____ Date employee last reported to work ____/____/____

Salary or wages as of last day reported for work \$ _____ Reason for leaving _____

Effective date of salary or wages reported above _____ Date on Which Premium Payments Ceased ____/____/____

Date of employment ____/____/____ Name of Group _____
Employer or Association

Date ____/____/____ Employer Phone # _____

Completed By _____ Date Completed ____/____/____
Signature and Official Title

PLEASE SEE THE INSTRUCTIONS ON THE OTHER SIDE

PART II CLAIMANT'S STATEMENT

1. Particulars regarding deceased:

- a) Name (in full) _____
b) State of legal domicile _____ c) Occupation _____
d) Date of birth ____/____/____ e) Date of death ____/____/____
f) Duration of last illness _____
g) Name and address of each attending physician _____

2. In what capacity or by what title do you claim this insurance money? _____

3. Relationship to deceased _____

4. What is your birth date? _____

5. Are you legally entitled to receive the whole of the monies payable under this policy, and to give the company a valid discharge therefor? _____

6. If benefits are payable in a lump sum, is any alternate form of settlement desired? (see reverse) _____

NOTICE - Filing a statement of claim containing any false, incomplete or misleading information with intent to defraud or deceive any insurance company is considered to be a felony in some states.

I hereby declare that the foregoing answers are true and full; that, to the best of my knowledge and belief, I have withheld no material facts from the Company and that the foregoing answers and statements are made with the object of securing payment to me of the proceeds of the above policy.

I expressly consent, authorize and direct any physician, surgeon, any law enforcement agency, or any other person who has examined or attended the deceased and every hospital or any other institution to which the deceased has applied for or in which the deceased has received treatment to disclose to the Company or its duly authorized representative any knowledge or information thereby acquired.

STATEMENT OF WITNESS

The claimant whose signature I have witnessed is known to me and signed this form in my presence.

Witness _____

Claimant - Please Print Full Legal Name _____

Claimant - Sign Full Legal Name _____

Street Address of Claimant _____

CLAIMANT'S Social Security or Taxpayer Identification Number _____

City State Zip

☐ CHECK THIS BOX IF YOU ARE NOT SUBJECT TO BACKUP WITHHOLDING UNDER SECTION 3406 OF THE IRS CODE. THIS INFORMATION IS REQUIRED BY THE INTERNAL REVENUE SERVICE.

Telephone Number (____) _____ Date ____/____/____

- 1. ATTACH OFFICIAL DEATH CERTIFICATE OR "ATTENDING PHYSICIAN'S CERTIFICATE" (GREAT-WEST LIFE FORM K1173)
2. FOR ALL ACCIDENT DEATH CLAIMS SUBMIT DETAILS OF THE ACCIDENT (NEWSPAPER CLIPPINGS OR POLICE REPORT). ADDITIONAL INFORMATION MAY BE REQUIRED, BUT THIS WILL BE OBTAINED DIRECTLY FROM THE AUTHORITIES BY GREAT-WEST HEALTHCARE.
3. ATTACH ENROLLMENT CARD AND ALL BENEFICIARY CHANGES ON FILE.

WHO SHOULD COMPLETE THE CLAIMANT'S STATEMENT

1. Where policy is payable to a named beneficiary -

The Claimant's Statement should be completed by the beneficiary except where a trustee was appointed by the deceased to act for him or where he is a minor or is otherwise unable to act for himself.

(a) Trustee for beneficiary -

Where a trustee was appointed by the deceased to act for the beneficiary, whether the beneficiary is of age or not, the trustee should complete the Statement.

(b) Minor beneficiary -

In certain States of the U.S.A. a beneficiary who is 18 years of age may complete the Statement. Otherwise, where the beneficiary is a minor and no trustee has been appointed, the legal Guardian of the Estate of the minor should complete the Statement and furnish a certified copy of his appointment. In some instances, the Official Guardian or Public Trustee may act for a minor.

(c) Beneficiary under disability -

In the case of a beneficiary who is unable to act for himself, the Guardian should complete the Statement and furnish a certified copy of his appointment.

2. Where policy is payable to the estate of the deceased -

The Claimant's Statement should be completed by the executors or administrators of the estate who should furnish a certified copy of their authority.

3. If there is no beneficiary designated or the beneficiary is not living at the time of the death of the insured, refer to Great-West Healthcare.

Amount of Proceeds

Settlement Options

\$ _____ (Minimum of \$5,000)	Term Deposit with interest at the rate in effect on the date this form is completed if received at the Head Office within 10 days, otherwise at option of the Company. Interest payable <input type="checkbox"/> annually <input type="checkbox"/> semi-annually <input type="checkbox"/> quarterly <input type="checkbox"/> monthly
\$ _____ (Minimum of \$1,000)	Deposit without term limit, with interest at policy rate payable <input type="checkbox"/> annually <input type="checkbox"/> semi-annually <input type="checkbox"/> quarterly <input type="checkbox"/> monthly
\$ _____ (Minimum of \$1,000)	Income of \$ _____ until proceeds with interest at policy rate exhausted, payable <input type="checkbox"/> annually <input type="checkbox"/> semi-annually <input type="checkbox"/> quarterly <input type="checkbox"/> monthly
\$ _____	Income for period of _____ years payable <input type="checkbox"/> annually <input type="checkbox"/> semi-annually <input type="checkbox"/> quarterly <input type="checkbox"/> monthly
\$ _____	Income for life with guaranteed period of <input type="checkbox"/> 10 years <input type="checkbox"/> 15 years <input type="checkbox"/> 20 years
\$ _____ (Minimum of \$10,000)	Ready Fund Account - Proceeds deposited into a fully guaranteed checking account, earning interest at competitive rates. All or part of the principal may be withdrawn at any time by writing a check against the account. Full information regarding this account, including a supply of free checks, will be provided upon claim approval.
\$ _____	Cash

Great-West Healthcare refers to products and services provided by Great-West Life & Annuity Insurance Company and its subsidiaries (Alta Health & Life Insurance Company and Great-West Healthcare HMO/HCSC companies). It also refers to the group business that is underwritten by New England Life Insurance Company and Metropolitan Life Insurance Company which is currently administered by Great-West Life & Annuity Insurance Company. Great-West Life & Annuity Insurance Company is not licensed to do business in New York. Products are sold in New York by its subsidiary First Great-West Life & Annuity Insurance Company, Albany, N.Y.