SET SEG
School Insurance Specialists

GROUP LIFE INSURANCE CLAIM

By furnishing this blank and investigating the claim, the Company shall not be held to admit the validity of any claim or to waive the breach of any condition of the Policy.

If death of insured employee or member, THIS CLAIM FORM COMPLETED AND SIGNED BY EMPLOYER OR PLAN ADMINISTRATOR and the CERTIFIED DEATH CERTIFICATE should be sent to: **SET SEG, 415 W. Kalamazoo, Lansing, MI 48933-2079**

If death resulted from other than natural causes, newspaper clippings, police or official reports, etc., should be furnished whenever possible.

INSURED INFORMATION

NAME OF INSURED EMPLOYEE _____ SOCIAL SECURITY NUMBER _____ BASIC ANNUAL EARNINGS _____

OCCUPATION _____ DUTIES _____

Insurance terminated prior to death? ☐ YES ☐ NO If yes, date terminated: _____/_____/_____

Reason why insurance was terminated (Specify whether resigned, discharged, retired or other): _____

_____

Amount of life insurance: LIFE $ _____ ACCIDENTAL DEATH $ _____

Date employed: _____/_____/_____ Date last worked full time: _____/_____/_____ HOUR _____ AM/PM _____

SELF-ADMINISTERED GROUP POLICYHOLDERS should attach the original enrollment card and all Beneficiary Change Forms

DECEASED INFORMATION

NAME OF DECEASED _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____

Relation: _____ Birth date: _____/_____/_____ Date of death: _____/_____/_____

Place of death: _____ Cause of death:: _____

Occupation accident: ☐ WORKER'S COMPENSATION REPORT ATTACHED

Accidental death - proof attachments: ☐ OFFICIAL REPORTS ☐ NEWSPAPER CLIPPINGS ☐ OTHER

BENEFICIARY INFORMATION

If insurance proceeds are payable to:
- estate of insured, a certificate of appointment of administrator or executor should be furnished.
- minor or mentally incompetent, a certificate of appointment of legal guardian should be furnished.

If designated beneficiary is deceased, a certified copy of the death certificate should be furnished.

1.

NAME _____ SOCIAL SECURITY NUMBER _____ AGE _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

2.

NAME _____ SOCIAL SECURITY NUMBER _____ AGE _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

3.

NAME _____ SOCIAL SECURITY NUMBER _____ AGE _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

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EMPLOYER

Do you recommend payment of claim? ☐ YES ☐ NO Remarks: _____

EMPLOYER

DATE | BY | TITLE | PHONE

ADDRESS | CITY | STATE | ZIP

LIFE INSURANCE CLAIM PHYSICIAN'S STATEMENT

(To be furnished without expense to the company if death certificate is not available).
In the interest of accurate vital statistics, please conform to the International List of Causes of Death.

FULL NAME OF DECEASED | RESIDENCE AT DEATH

Age at death or date of birth: _____/_____/_____ Date of death: _____/_____/_____

Place of Death (if hospital or institution, give name): _____

CAUSE OF DEATH (Enter only one cause for each of a, b, and c) | **INTERVAL BETWEEN ONSET AND DEATH**

Disease or condition directly leading to death: (This does not mean the mode of dying, such as heart failure, asthenia, etc. It means disease, injury or complication which caused death)

A. _____ **A.** _____

Antecedent Causes (Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last)

DUE TO B. _____ **B.** _____

DUE TO C. _____ **C.** _____

Other significant conditions: (Contributing to the death but not related to the disease or condition causing death) _____

DATE OF FIRST ATTENDANCE IN LAST ILLNESS | **DATE OF LAST ATTENDANCE IN LAST ILLNESS**

If death was due to accident, suicide or homicide, specify which. Describe briefly.

_____

_____

Was an inquest held? ☐ YES ☐ NO
Was an autopsy performed? ☐ YES ☐ NO
If so, by whom and with what findings? ☐ YES ☐ NO

_____

Have you treated or advised the deceased during the last 5 years, prior to the last illness? ☐ YES ☐ NO
Did the deceased, to your knowledge, receive treatment during the last 5 years from any other physician, or hospital or institution? ☐ YES ☐ NO
If yes to either question, please furnish the following:

NAME OF PHYSICIAN OR INSTITUTION | ADDRESS | NATURE OF ILLNESS | DATES

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☐ These statements are true and complete to the best of my knowledge and belief.

SIGNATURE | M.D. | DATE

ADDRESS

Send completed form to: SET, Inc. | Attn Life & Disability Claims
415 W. Kalamazoo St. Lansing, MI 48933-2079 | Fax (517) 482-4181

REV. 8/10/15