Group Life Insurance
Proof of Loss Accidental Death Insurance

MCS Life Insurance Company

Any person who is knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information or conceal for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

INSTRUCTIONS

This form is for Life Insurance or Accidental Death proceeds only. This claim will be subject to delay or return if these instructions are not followed.

To the Employer-Administrator:

• Attach beneficiary form • Please submit newspaper clips if available • Submit completed form to the assigned Claim Officer with a certified Death Certificate

Name of Employee (Last) (Middle) (Middle Initial)		Social Security Number	Date of Birth	Sex ☐ Male ☐ Female
Address (Street)		(City)	(State)	(Zip Code)
Was insurance issued on the basis of a statement of physical condition? ☐ YES ☐ NO *If yes, attach copy*		Policy Number(s) Including AD & D policy no. if different)	Occupation	
Please check the appropriate blocks regarding the insured's employment status ☐ Active ☐ Exempt ☐ Management ☐ Supervisory ☐ Union Local# ____ ☐ Full-Time ☐ Salaried ☐ Retiree ☐ Non-Exempt ☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Part-Time ☐ Hourly			Hrs/Wk # _____	
Amount in of Insurance Basic: _____ Supp:_____ AD&D: _____	Date of Last Increase in Benefits	Date of Last Change in Earnings	Basic Annual Earnings	
Effective Date of Insurance	Premium Paid Thorough Date	% of Insured's Contribution to Premium	Date of Hired/Member of Association	Last Date Worked
Was coverage still in effect through date of death? If not, please explain		Was the above considered an employee/Association member until date of death? If not, please explain		

Please Complete This Section if Claim is for Dependent Benefits

Name of Dependent (Last) (Middle) (Middle Initial)		Social Security Number	Date of Birth	Sex ☐ Male ☐ Female
Amount of Dependent Insurance	Relationship to the Employee/Association Member		Dependent's Occupation	
If child ☐ Full-Time Student ☐ Part-Time Student	Name and Address of School			

Please Complete This Section if Claim is for Accidental Death Benefits

Where and how did the accident happen? Please describe in detail.

Date and Time of Accident	What diseases, illness or injuries did the deceased have during the past 3 years?

Please list any hospitals, clinics or physicians that treated the deceased during the past 3 years

Name Treatment Period Complete Address

Beneficiary Information

Name of the Deceased Person: (Middle) (Middle Initial)			Date of Birth	Sex ☐ Male ☐ Female
Address during past month (Street)		(City)	(State)	(Zip Code)
Policy Number	Certificate Number	Amount of Insurance	Date of Elegibility	Coverage Classification
Date of		Place of		
Beneficiary Name	Relationship with deceased	Age	Address (Also include the name of Legal Guardian if Beneficiary is a Minor)	

Employer's /Administrator's Certification

Name of Employer			Division	
Address (Street)	(City)	(State)	(Zip Code)	Telephone

This is to certify that the facts as indicated above are true to the best of my knowledge and belief.

Signature of Authorized Representative	Tittle	Date Signed

The issuance of this blank is not an admission of the existence of any insurace nor does it recognize the validity of any claim and without prejudice to the Company's legal rights in the premises.

Form E1095-I1/1