



BEST Life and Health Insurance Company

P.O Box 19721, Irvine, CA 92623-9721
(800) 433-0088 • (949) 222-1004 fax
www.bestlife.com

Proof of Death
Group Term Life

STATEMENT OF POLICYHOLDER
Name of Deceased Employee, Phone Number, Date of Employee's Birth, Date of Employee's Death, Address of Employee, Group Policy No., Certificate No., Amount of Life Insurance, Name and Address of Employer, Phone Number, Type of Employment, Hours Worked Per Week, Weekly Earnings, Duration of Employment, Disability Benefits were Paid, Carrier's Name, Date of premium payments, Last day of full time active work, Insurance Class, Reason for stopping work, Beneficiary (if estate, attach a certified copy of court order appointing executor or administrator), Guardian (if beneficiary is a minor, attach a certified copy of court order appointing guardian), Signature of Policyholder's Official Representative, Print Name of Signature Above, Telephone Number.

ATTENDING PHYSICIAN'S STATEMENT
If the deceased was disabled more than 31 days prior to death, please have this statement completed by the physician who treated during this disability.
Name of Deceased, Date of Death, Age, Place of Death, Date of first visit, Date of last visit, Immediate Cause of Death, Duration, Contributory Causes or Complications, Duration, Death Resulted From, If due to accident, suicide, or homicide, describe briefly, The Deceased was totally disabled and unable to perform work, I hereby certify that the above answers are true and complete to the best of my knowledge and belief, Name of attending physician (please print), Telephone Number, Street Address, City, State, ZIP, Signature, Date.

THE ORIGINAL ENROLLMENT CARD OR APPLICATION FOR INSURANCE SHOULD ACCOMPANY THIS FORM, IF MAINTAINED BY THE POLICYHOLDER.

BY FURNISHING THIS BLANK INVESTIGATING 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.

FRAUD WARNING: AS REQUIRED BY LAW, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH MAY BE CONSIDERED CRIME.

**PLEASE COMPLETE REVERSE**

CLAIMANT'S STATEMENT			
Full Name of Deceased		Date of Birth	Date of Death
Cause of Death		Place of Death	
Provide date that deceased first complain of, or give indication of his/her last illness		Provide date that deceased first consulted a physician for last illness	
Was death result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Accident	Place of Accident	Did accident occur in the course of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe accident briefly			
Names and addresses of all physicians who attended the deceased and of all hospitals and institutions where he/she was treated during the last illness and during five years prior thereto			
Name	Address	Date	Disease/Condition
Facts concerning other life, health and accident insurance carried by deceased.			
Company	Policy Number	Amount of Insurance	
Original certificate of insurance must be returned if available		In what capacity did you claim this insurance (if administrator, executor or guardian, attach copy of court order appointment)	
<input type="checkbox"/> Certificate enclosed <input type="checkbox"/> Certificate cannot be located			
Your Date of Birth	Your Social Security Number	Estate Tax ID/Trust Tax ID (provide if claim made by estate or trust)	
I elect to receive payment by <input type="checkbox"/> lump sum direct payment by check. <input type="checkbox"/> other settlement option (Please specify and if necessary, contact your insurance plan administrator for a description of other settlement options available) _____.			
These statements are true and complete to the best of my knowledge and belief. I understand that the furnishing of forms by the Company does not constitute an admission that there is any insurance in force. I hereby authorize and request any hospital, physician, pharmacist, employer, insurance company or other person or entity to whom this is presented to furnish BEST Life and Health Insurance Co. or its representative, any and all information and records (or copies thereof) it may desire, specifically to include testing and/or treatment of Human Immunodeficiency (HIV) or AIDS, concerning the deceased and further agree that such information or records shall constitute and are hereby made a part of the Proofs of Death. A photostatic copy of this authorization shall be as valid as the original. Furthermore, in the event an instant access account is opened, the Signature of Claimant(s) presented on this claim form will be used for signature verification.			
Under penalty of perjury, I certify that the Social Security/Tax ID number provided on this form is true, correct, and complete. I understand that failure to furnish this number can subject me to back-up withholding. I certify that I am not now subject to back-up withholding.			
Print Claimant's Name		Signature of Claimant, with Title, if any	
Witness		Date	
Address		Telephone number	
BY FURNISHING THIS BLANK INVESTIGATING 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.			

## INSTRUCTIONS FOR FILING A GROUP DEATH CLAIM

In order to ensure that we provide prompt service and to be as helpful to you as possible, please submit the enclosed claim form with all three sections completed as follows:

**The “Statement of Policyholder” section** is to be completed and signed by an authorized representative of the policyholder (employer).

**The “Attending Physician’s Statement” section** is only to be completed if the deceased was disabled for at least 31 days preceding death. Only a physician who treated for the disability should be asked to complete this section.

**The “Claimant’s Statement” section** is to be completed and signed by the designated beneficiary. If no beneficiary has been designated, then the statement should be completed and signed by either the Executor or Administrator of the decedent’s estate. Certified estate papers should also be submitted along with the claim. In the event the designated beneficiary is a minor, the Guardian of the Property/Estate of such minor beneficiary will need to complete and sign this section. Certified guardianship papers will also be required at the time of submission.

### **Return the Proof of Group Death Claim Form with**

- (1) an original or certified copy of the death certificate,
- (2) the deceased’s certificate of insurance and
- (3) the original enrollment card

If death took place in a foreign country and the death certificate was issued by that country, it should be certified by an official of the American Consulate within that country.

In the event that your life insurance is based on salary, please forward a copy of the decedent’s pay records for the last quarter of full-time active work.

The claim form will be processed once the Company has received all of the above items along with a completed claim form. By furnishing this form and requesting material, the Company does not waive any defenses or rights it has or may have relating to this matter.

For questions, please call our Claims Department at (800) 433-0088. All documents should be mailed to:

BEST Life and Health Insurance Company  
P.O. Box 890  
Meridian, ID 83890  
(800) 433-0088