## DEPENDENT DEATH CLAIM FORM
## GROUP INSURANCE

P.O. BOX 7777 - MERIDIAN, IDAHO 83680-7777
(800) 657-6351

**By furnishing this form and investigating the claim the Company shall not be held to admit validity of any claim or to waive the breach of any condition of the policy. The Company reserves the right to require and obtain such additional statements and information as it deems necessary.**
**The laws of some states require us to furnish you with the following notice: It is unlawful to knowingly file a claim statement that provides materially false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. The company is required to report suspected fraudulent activity to the Department of Insurance or appropriate regulatory authorities.**

**INSTRUCTIONS**

A. Employer complete and sign this statement.
B. Obtain from the employee a Certified Copy of the Death Certificate.
C. Mail (a) this form, (b) the certified Death Certificate and (c) a copy of the enrollment card to United Heritage Life Insurance Company at the address above.

| 1. Employer | 2.Employer Telephone # ( ) area code | | 3. Group Policy Number |
|---|---|---|---|
| 4. Employee's Name | 5. Social Security # | 6. Sex | 7. Date of Birth |
| 8. Residence (Street, City, State, Zip Code) | 9. Date Employed | | 10. Occupation |

| 11. Effective Date of Insurance | 12. Was Insurance Terminated? ( ) Yes ( ) No If Yes, give Date |
|---|---|

13. How many hours per week did the employee work immediately prior to his dependent's death?

14. How many weeks did the employee work in the 52 weeks immediately prior to his dependent's death?

15. Was he/she considered an employee on date of dependent's death? ( ) Yes ( ) No
If no, explain

16. If not still actively at work, give date last worked

17. Reason for leaving work: ( ) Disability (Including Disability Leave of Absence) ( ) Leave of Absence (Other than Disability)
( ) Quit ( ) Retired ( ) Dismissed ( ) Vacation ( ) Temporary Layoff ( ) Other ___________________________

| 18. Dependent's Name | 19. Date of Birth | 20. Relationship ( ) Wife ( ) Husband ( ) Child |
|---|---|---|

| 21. Date of Death | 22. Cause of Death, if Known | 23. Amount of Insurance | 24. Last Change in Amount of Insurance<br>Decrease $ ____________________<br>Increase $ ______________________ | 25. Date of Change |
|---|---|---|---|---|

26. If spouse, was he/she divorced or legally separated from employee on date of death?

27. If child, was he/she Married? ( ) Yes ( ) No Student? ( ) Yes ( ) No
Employed? ( ) Yes ( ) No If Yes, was employment ( ) Full Time ( ) Part Time Date Employed______________

| 28. Date Insured | 29. Was Insurance terminated? ( ) Yes ( ) No If Yes, give Date |
|---|---|

We believe that this dependent was eligible and insured under the provisions of the group policy and as indicated by the information shown above.

Employer ________________________________________________________________

By __________________________________________________________________

Title ________________________________________ Date ____________________

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