



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, 1520 Earl Ave., East Lansing, MI 48823**

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
1520 Earl Ave., East Lansing, MI 48823 | Fax (517) 482-4181

Phone: (800) 292-5421 | Email: customerservice@setseg.org