Group Insurance Death Claim Statement

TEAMSTERS LIFE INSURANCE TRUST FUND

(925) 833-7315 4160 Dublin Blvd., Suite 100 ♦ Dublin, CA 94568-7756 (925) 223-8290 FAX

SECTION 1 **Local Union's Statement**

Deceased:

Name

Address City, State, Zip

Date of Death Birth Date

Age at Death S.S.#:

Cause of Death

Name of Employer Date Employed

Last Sub-Group Employer

Was deceased collecting a pension from:
Western Conference of Teamsters? Yes X No
Western States pension? Yes No
If "Yes" state:
Effective Date:
Normal or Disability:

Beneficiary:

Name – as shown on the records and certificate
If none designated, write "none"

Address

City, State, Zip

Last date actively worked

Effective date of insurance for last sub-group employer

	Status	Sub-Group	Amt. of Life Insurance
Policy #109913-1G:	ACTIVE	0114690	
Policy #109913-1G:	ACT PAD&D	0113383	
Policy #109913-2G:	RETIREE	0117527	
	Retiree	113383 0002 0001	
	Retiree	110799 0001 0001	

Effective date of deceased's insurance

Date through which premiums paid for deceased's insurance

Name of Group Policyholder:

Was date last worked more than 31 days prior to date of death? No Yes If "Yes", answer the following:
Was deceased on leave of absence? No Yes
Was deceased on temporary layoff? No Yes
Was deceased totally disabled? No Yes If "Yes", Date disability commenced
Was deceased's employment terminated? If "Yes", date of termination
Give reason

Was a disability claim filed with insurer? No Yes

Local Union Signature Title Date ( ) Telephone No.

SECTION 2 **Administrator's Statement**

Our records show that the deceased person named above ____ (had) or ____ (had not) fully qualified with the eligibility requirements for life insurance under this policy, and that such life insurance in the amount specified above ____ (was) or ____ (was not) in force, according to the terms of this policy, at the date of his/her death.

Administrator Signature Title Date

SECTION 3 **Beneficiary's Statement**

I, the undersigned, hereby make claim for the insurance mentioned above. I also authorize any physician or practitioner who attended the deceased at any time, or any hospital or other institution (including any Veteran's Administration Facility Hospital in which the deceased may have been a patient or inmate at any time), to disclose to said Company or testify to any information thus acquired, to the extent permitted by provisions of the law. A copy or photocopy of this authorization shall be as valid as the original.

Please print or type claimant's name

Claimant's S.S.# or Tax I.D.#

( ) Telephone No.

Claimant's Mailing Address

Claimant's Relationship to Deceased

Date of Birth (Claimant)

City, State, Zip

Claimant's Signature

Date Signed

Statement Continued on the back

INSTRUCTIONS

Please see that every question is answered and the supporting documents are present, thus avoiding delay and assuring prompt action of the claim.

Are the following attached:

No Yes

Death Certificate – A certified copy of the official document.

Group Insurance Certificate of the deceased, if it is available.

Insured's Enrollment Card, if maintained by the Policyholder or Administrator.

Beneficiary Change Requests completed by the insured, if any.

Appointment of Guardian if any insurance is to be paid to a minor beneficiary.
A certified copy of such appointment by the Court may be required before payment is made.

Appointment of Executor or Administrator if any insurance is to be paid to the estate of the deceased
A certified copy of such appointment by the Court may be required before payment is made.

Death Certificate of the Deceased Beneficiary, if the designated beneficiary predeceased the insured.
A certified copy will be required.

G 6926-889 if any insurance is to be paid to a preference beneficiary. If no beneficiary was designated, or if the designated beneficiary predeceased the insured, then the insurance becomes payable to the first surviving class of the following classes of successive preference beneficiaries.

(1) The spouse of the deceased insured.
(2) The child or children of the deceased insured.
(3) The parents of the deceased insured.
(4) The brothers and sisters of the deceased insured.
(5) The executor or administrator of the estate of the deceased insured.

If more than one beneficiary is entitled to receive the insurance proceeds, only one of the beneficiaries need sign the Beneficiary Statement on the reverse side, but the names, addresses, birthdates and social security numbers of all other beneficiaries should be given below.

Name Social Security Number

Address

City, State, Zip Code

Relationship to Deceased Date of Birth

Name Social Security Number

Address

City, State, Zip Code

Relationship to Deceased Date of Birth

Name Social Security Number

Address

City, State, Zip Code

Relationship to Deceased Date of Birth

Name Social Security Number

Address

City, State, Zip Code

Relationship to Deceased Date of Birth

Name Social Security Number

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