

BEST LIFE and Health Insurance Company
 Principal Executive and Claims Office:
 2505 McCabe Way • Irvine, CA 92614
 (949) 253-4080 • FAX (949) 222-1004

GROUP LIFE CLAIM

STATEMENT OF GROUP INSURANCE ADMINISTRATOR - INSTRUCTIONS ON REVERSE SIDE

NAME OF DECEASED	<input type="checkbox"/> INSURED <input type="checkbox"/> DEPENDENT	DATE OF BIRTH
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DECEASED'S ADDRESS

POLICY NUMBER	JOB TITLE	NO OF HOURS WORKED PER WEEK	SALARY \$	<input type="checkbox"/> HR <input type="checkbox"/> WK <input type="checkbox"/> MO	DATE OF LAST SALARY INCREASE OR INCREASE IN BENEFITS	AMOUNT OF INSURANCE	
						LIFE \$	AD&D \$
DATE EMPLOYED		EFFECTIVE DATE OF INSURANCE		DATE LAST WORKED FULL TIME		DATE PREMIUM PAID TO FOR DECEASED	

IF DATE LAST WORKED WAS MORE THAN 31 DAYS PRIOR TO DEATH, WAS DECEASED-

- | | | |
|--|-----------------------------|---|
| 1 TOTALLY DISABLED | <input type="checkbox"/> NO | <input type="checkbox"/> YES - DATE OF TOTAL DISABILITY _____ |
| 2 LEAVE OF ABSENCE OTHER THAN DISABILITY | <input type="checkbox"/> NO | <input type="checkbox"/> YES - LEAVE OF ABSENCE DATE _____ |
| 3 TEMPORARY LAYOFF | <input type="checkbox"/> NO | <input type="checkbox"/> YES - DATE OF LAYOFF _____ |
| 4 RETIRED | <input type="checkbox"/> NO | <input type="checkbox"/> YES - DATE RETIRED _____ |
| 5 TERMINATED - DATE _____ | | |
| 6 VACATION | <input type="checkbox"/> NO | <input type="checkbox"/> YES |

WAS DEATH CAUSED BY ACCIDENT?	WAS ACCIDENT ON THE JOB?	DATE OF ACCIDENT	PLACE
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		

BENEFICIARIES' NAMES AND ADDRESSES AS SHOWN BY YOUR RECORDS	SOCIAL SECURITY NUMBER	RELATIONSHIP	DATE OF BIRTH
NAME			
ADDRESS			
NAME			
ADDRESS			
NAME			
ADDRESS			
NAME			
ADDRESS			

REMARKS

EMPLOYER'S NAME AND ADDRESS	POLICYHOLDER'S NAME & ADDRESS (IF OTHER THAN EMPLOYER)		
SIGNED	TITLE	TELEPHONE #	DATE

INSTRUCTIONS

1. Fully complete this form and submit:

- **Certified death certificate.**
- The original enrollment card and any requests for change of beneficiary.
- Certificate of insurance, if available.
- Copy of monthly billing in which insured was deceased.

2. If beneficiary is:

- A Minor or Incompetent - Submit certified copy of guardian's letters of appointment, if a guardian has been appointed. If no guardian has been appointed furnish full name and address of person who has custody of the minor or incompetent.
- Estate - Submit a certified copy of the appointment of the Executor or Administrator. If estate is not to be probated furnish name, address and relationship of next-of-kin under **Remarks**.
- Deceased - Submit certified death certificate of beneficiary.
- Not Designated or Deceased - Affidavit of Preference Beneficiary, Form G0003, should be completed by a member of the first surviving class of successive beneficiaries listed below:
 - Spouse
 - Children
 - Parents
 - Brothers & Sisters
(Refer to your policy, omitted in some policies.)
 - Estate