



GROUP LIFE BENEFITS DEPARTMENT
LIFE CLAIM REPORT

Return to:
Great-West Life
Group Life and Disability
8525 East Orchard Road, 5T3
Greenwood Village, CO 80111
Telephone Number: 1-800-537-2033

PART I EMPLOYER'S OR ADMINISTRATOR'S STATEMENT

Name of Deceased SS No. Group Policy No:
Address Street City State
If dependent claim, provide name of employee and relation to deceased
Amount of Life Insurance Benefit \$ Amount of Optional Life Insurance Benefit \$
Amount of the Accidental Death Benefit (If Applicable) \$ Date employee last reported to work
Salary or wages as of last day reported for work \$ Reason for leaving
Effective date of salary or wages reported above Date on Which Premium Payments Ceased
Date of employment Name of Group Employer or Association
Date Employer Phone #
Completed By Signature and Official Title Date Completed

PLEASE SEE THE INSTRUCTIONS ON THE OTHER SIDE

PART II CLAIMANT'S STATEMENT

1. Particulars regarding deceased:
a) Name (in full)
b) State of legal domicile c) Occupation
d) Date of birth e) Date of death
f) Duration of last illness
g) Name and address of each attending physician
2. In what capacity or by what title do you claim this insurance money?
3. Relationship to deceased
4. What is your birth date?
5. Are you legally entitled to receive the whole of the monies payable under this policy, and to give the company a valid discharge therefor?
6. If benefits are payable in a lump sum, is any alternate form of settlement desired? (see reverse)

NOTICE - "For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison". California Insurance Code § 1879.2
I expressly consent, authorize and direct any physician, surgeon, any law enforcement agency, or any other person who has examined or attended the deceased and every hospital or any other institution to which the deceased has applied for or in which the deceased has received treatment to disclose to the Company or its duly authorized representative any knowledge or information thereby acquired.

STATEMENT OF WITNESS

The claimant whose signature I have witnessed is known to me and signed this form in my presence.

Witness

Claimant - Please Print Full Legal Name

Claimant - Sign Full Legal Name

Street Address of Claimant

CLAIMANT'S Social Security or Taxpayer Identification Number

CHECK THIS BOX IF YOU ARE NOT SUBJECT TO BACKUP WITHHOLDING UNDER SECTION 3406 OF THE IRS CODE. THIS INFORMATION IS REQUIRED BY THE INTERNAL REVENUE SERVICE.

City State Zip

Telephone Number ( ) Date / /

- 1. ATTACH OFFICIAL DEATH CERTIFICATE OR "ATTENDING PHYSICIAN'S CERTIFICATE" (GREAT-WEST LIFE FORM K1173)
2. FOR ALL ACCIDENT DEATH CLAIMS SUBMIT DETAILS OF THE ACCIDENT (NEWSPAPER CLIPPINGS OR POLICE REPORT). ADDITIONAL INFORMATION MAY BE REQUIRED, BUT THIS WILL BE OBTAINED DIRECTLY FROM THE AUTHORITIES BY GREAT-WEST LIFE.
3. ATTACH ENROLLMENT CARD AND ALL BENEFICIARY CHANGES ON FILE.

## WHO SHOULD COMPLETE THE CLAIMANT'S STATEMENT

### 1. Where policy is payable to a named beneficiary -

The Claimant's Statement should be completed by the beneficiary except where a trustee was appointed by the deceased to act for him or where he is a minor or is otherwise unable to act for himself.

(a) Trustee for beneficiary -

Where a trustee was appointed by the deceased to act for the beneficiary, whether the beneficiary is of age or not, the trustee should complete the Statement.

(b) Minor beneficiary -

In certain States of the U.S.A. a beneficiary who is 18 years of age may complete the Statement. Otherwise, where the beneficiary is a minor and no trustee has been appointed, the legal Guardian of the Estate of the minor should complete the Statement and furnish a certified copy of his appointment. In some instances, the Official Guardian or Public Trustee may act for a minor.

(c) Beneficiary under disability -

In the case of a beneficiary who is unable to act for himself, the Guardian should complete the Statement and furnish a certified copy of his appointment.

### 2. Where policy is payable to the estate of the deceased -

The Claimant's Statement should be completed by the executors or administrators of the estate who should furnish a certified copy of their authority.

### 3. If there is no beneficiary designated or the beneficiary is not living at the time of the death of the Insured, refer to Great-West Life.

#### Amount of Proceeds

#### Settlement Options

|                                |  |
|--------------------------------|--|
| \$ _____<br>(Minimum \$5,000)  | Term Deposit with interest at the rate in effect on the date this form is completed if received at the Head Office within 10 days, otherwise at option of the Company.<br>Interest payable<br><input type="checkbox"/> annually <input type="checkbox"/> semi-annually <input type="checkbox"/> quarterly <input type="checkbox"/> monthly   |
| \$ _____<br>(Minimum \$1,000)  | Deposit without term limit, with interest at policy rate payable<br><input type="checkbox"/> annually <input type="checkbox"/> semi-annually <input type="checkbox"/> quarterly <input type="checkbox"/> monthly   |
| \$ _____<br>(Minimum \$1,000)  | Income of \$ _____ until proceeds with interest at policy rate exhausted, payable<br><input type="checkbox"/> annually <input type="checkbox"/> semi-annually <input type="checkbox"/> quarterly <input type="checkbox"/> monthly  |
| \$ _____                       | Income for period of _____ years payable<br><input type="checkbox"/> annually <input type="checkbox"/> semi-annually <input type="checkbox"/> quarterly <input type="checkbox"/> monthly   |
| \$ _____                       | Income for life with guaranteed period of<br><input type="checkbox"/> 10 years <input type="checkbox"/> 15 years <input type="checkbox"/> 20 years   |
| \$ _____<br>(Minimum \$10,000) | Ready Fund Account - Proceeds deposited into a fully guaranteed checking account, earning interest at competitive rates. All or part of the principal may be withdrawn at any time by writing a check against the account. Full information regarding this account, including a supply of free checks, will be provided upon claim approval. |
| \$ _____                       | Cash   |

Great-West Healthcare refers to products and services provided by Great-West Life & Annuity Insurance Company and its subsidiaries (Alta Health & Life Insurance Company and Great-West Healthcare HMO/HCSC companies). It also refers to the group business that is underwritten by New England Life Insurance Company and Metropolitan Life Insurance Company which is currently administered by Great-West Life & Annuity Insurance Company. Great-West Life & Annuity Insurance Company is not licensed to do business in New York. Products are sold in New York by its subsidiary First Great-West Life & Annuity Insurance Company, White Plains, N.Y.