American International Companies ®
Insurance Company of the State of Pennsylvania
MAIL TO:

Adventist Risk Management, Inc.
12501 Old Columbia Pike
Silver Spring, MD 20904
Email: claims@adventistrisk.org

Phone: (301) 680-6870
FAX (301) 680-6878

PROOF OF LOSS - ACCIDENTAL DEATH

NAME OF GROUP:

POLICY NUMBER:

GROUP POLICYHOLDER/EMPLOYER INSTRUCTIONS

In order to assure prompt processing of this claim, please forward the claim form to the Beneficiary. The Employer/Administrator must complete PART A in its entirety. Due to recent changes in tax laws, the Beneficiary will be required to complete PART B. Be certain that PART C on the reverse side is completed fully and signed by the Beneficiary.

Return this form to the above address.

In addition to the claim form, the following items are required:
(1) A Certified Copy of the final death certificate;
(2) Your company's enrollment benefits form and Beneficiary Designation;
(3) Confirmation of employee's Principal Sum and current premium payment;
(4) The Police Report, any Autopsy Report, and any newspaper clippings.
(5) If Business Travel, a copy of employee's itinerary prior to the accident, purpose of the trip, destination to and from trip, and confirmation that trip was authorized by the company.

Every question must be fully answered. We reserve the right to require or to obtain further information should it be deemed necessary. If there is more than one beneficiary, all may join in one statement, or a separate form will be furnished for each if desired.

PART A: GROUP POLICYHOLDER/EMPLOYER INFORMATION

GROUP POLICYHOLDER/EMPLOYER ADDRESS

DIVISION NAME AND ADDRESS	ACCIDENTAL DEATH BENEFIT IN FORCE $

EMPLOYEE'S NAME AND ADDRESS	DATE EMPLOYED	DATE OF BIRTH

EFFECTIVE DATE OF COVERAGE	SOCIAL SECURITY NUMBER	DATE OF DEATH	OCCUPATION

TERMINATION DATE OF COVERAGE	INSURANCE CLASS	SALARY ON DATE LAST WORKED (HRLY/WKLY/MTHLY/ANNLY)	DATE PREMIUM PAID TO

DATE LAST WORKED

STATUS ON DATE LAST WORKED

□ ACTIVE □ RETIRED □ PREMIUM WAIVER FOR DISABILITY □ APPROVED LEAVE OF ABSENCE (EXPLAIN) □ OTHER

EMPLOYEE WAS: □ HOURLY □ SALARIED □ COMMISSIONED □ OTHER (EXPLAIN)

If Claim is For Dependent, Provide the Following:

DEPENDENT'S NAME AND ADDRESS	SOCIAL SECURITY NUMBER	RELATIONSHIP	AMOUNT OF BENEFIT

DEPENDENT'S OCCUPATION	DEPENDENT'S DATE OF BIRTH	NAME AND ADDRESS OF EMPLOYER

GROUP POLICYHOLDER/EMPLOYER SIGNATURE

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE SIGNED	PLACE (CITY, STATE)	PHONE NUMBER

GROUP POLICYHOLDER/EMPLOYER	BY (THEIR AUTHORIZED REPRESENTATIVE)

PART B: IMPORTANT TAX INFORMATION

To Be Completed by
Social Security Number/
Tax ID Number

Beneficiary

Please Print or Type Name of Claimant

Under penalties of perjury, I certify: (1) that the Social Security/Tax ID Number shown above is my correct Social Security or Taxpayer Identification Number.

Be Certain Part C on the Reverse Side is Completed

PART C: BENEFICIARY INFORMATION

In order to assure prompt processing, please be certain the authorization below is signed by the beneficiary. The completed and signed claim form along with the Certified Death Certificate, Police Report, Autopsy Report, and any newspaper clippings should be returned to the Employer/Administrator.

NAME OF BENEFICIARY	RELATIONSHIP TO DECEDENT	BENEFICIARY'S DATE OF BIRTH

NOTE: If any designated beneficary is deceased, submit that beneficiary's certified Death Certificate. If the beneficiary is the Deceased's estate, furnish certified letters of Administration or Letters of Testamentary, and Estate Tax ID Number. If the beneficiary is a minor, furnish certified Letters of Guardianship for the minor's estate and minor's social security number.

WHEN DID ACCIDENT HAPPEN? (MONTH, DAY, YEAR)	TIME ☐ A.M. ☐ P.M.	WHERE DID ACCIDENT HAPPEN? (IF CITY OR TOWN, SHOW STREET NUMBER)

WHAT WAS CAUSE OF DEATH?	DATE OF DEATH (MO., DAY, YEAR) ATTACH COPY OF DEATH CERTIFICATE.

WHEN DID SYMPTOMS OF CAUSE OF DEATH FIRST APPEAR?

HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY)

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED DECEASED FOR THESE INJURIES CAUSING DEATH.

NAME & ADDRESS	NAME & ADDRESS	NAME & ADDRESS

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED DECEASED DURING THE LAST FIVE YEARS (STATE AILMENTS INVOLVED).

NAME	ADDRESS	AILMENT
NAME	ADDRESS	AILMENT

LIST ALL WITNESSES TO ACCIDENT.

NAME & ADDRESS	NAME & ADDRESS	NAME & ADDRESS

LIST OTHER COVERAGES AND AMOUNTS OF INSURANCE IN FORCE ON DECEASED'S LIFE.

NAME OF COMPANY	POLICY NUMBER	EFFECTIVE DATE	AMOUNT OF INSURANCE
NAME OF COMPANY	POLICY NUMBER	EFFECTIVE DATE	AMOUNT OF INSURANCE

HAVE DIVORCE PROCEEDINGS EVER BEEN INSTITUTED BY OR AGAINST THE DECEASED? IF YES, INDICATE WHEN, WHERE AND THE OUTCOME.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

For claimants not residing in California, New York, or Pennsylvania: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE OF BENEFICIARY, AUTHORIZED REPRESENTATIVE, OR NEXT OF KIN	DATE SIGNED (MONTH, DAY, YEAR)	
ADDRESS OF NEXT OF KIN (NO., STREET, CITY, STATE)	BUSINESS PHONE NUMBER	HOME PHONE NUMBER
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