DEATH CLAIM FORM - INT'L SURVIVOR BENEFIT FUND TRUST

Please mail completed forms and documentation to:

Adventist Risk Management, Inc.
12501 Old Columbia Pike
Silver Spring, MD 20904-6600
Phone: 301-680-6870
Fax: 301-680-6878
Email: claims@adventistrisk.org

By furnishing this blank and investigating the claim Adventist Risk Management, Inc. shall not be held to admit the validity of any claim or to write to waive the breach of any condition of the Master Agreement

TO BE COMPLETED BY EMPLOYER ***USE THIS FORM ONLY IF THE DEATH OCCURRED ON OR AFTER JUNE 1, 2005***

Adventist Risk Management, Inc. Int'l Survivor Benefit Fund Trust #6105AFD		Address: 12501 Old Columbia Pike, Silver Spring, MD 20904	
Name of Division		Name of Employing Organization	
Print Name of Authorized Employer Representative		Signature of Employer Representative Title	
NAME OF **EMPLOYEE** Last First Middle Initial		Date of Birth (dd/mm/yy)	Social Security No. or ID No
Date of Hire (dd/mm/yy)	Annual Income	**Date Last Worked** (dd/mm/yy)	**Date Employment Terminated**
Int'l SB Effective date (dd/mm/yy)	Change in Benefit Date: From (amount): To (amount):	Employee Benefit amount: USD: Spouse Benefit amount: USD:	
Name of **DECEASED** Last First Middle Initial		Who died? □ Employee □ Spouse	**Date of Death** (dd/mm/yy)
Cause of Death (**Please attach death certificate – original only**)		Occupation of **Employee**	**Full-time** □ **Weekly hours** **Part-time** □ _____

Name of Beneficiary(s)	Relationship to Deceased	Date of Birth dd/mm/yy	Beneficiary Signature	Address
	Spouse			

If beneficiary(s) are minors and surviving spouse is not a beneficiary, attach Court appointed Legal Guardianship papers. For all minors attach copies of birth certificates.

Use the back of this form if additional lines are needed for beneficiaries.

The undersigned hereby makes claim to Adventist Risk Management, Inc. and agrees that the written statements and affidavits of all the physicians attended or treated the Insured, and all other papers called for shall constitute and are hereby made a part of these Proofs of Death, and further agrees to the furnishing of this form or any other forms supplement thereto, by Adventist Risk Management, Inc., shall not constitute nor be considered an admission by it that there was any benefit available on the life in question, nor a waiver of its rights or defenses.

The undersigned hereby authorizes all physicians, hospitals, druggists and employers to disclose to Adventist Risk Management, Inc., its representative, and any all of information with respect to medical history, consultation, prescription or treatments and copies of all medical records of _____, deceased.

I understand that this authorization is valid for the duration of this claim and that a photocopy 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. I certify that the above information is true and correct to the best of my knowledge and belief.

Signed _____ Date_____ Witness _____
Primary Beneficiary (or Legal Guardian)

CLAIM NUMBER	**CLAIMS EXAMINER**	**DATE**

DEATH CLAIM FORM - INT'L SURVIVOR BENEFIT FUND TRUST

Please mail completed forms and documentation to:

Adventist Risk Management, Inc.
12501 Old Columbia Pike
Silver Spring, MD 20904-6600
Phone: 301-680-6870
Fax: 301-680-6878
Email: claims@adventistrisk.org

(Benefits are payable only to the beneficiary(s) whose name(s) are listed on the application, or whose names were added and signed by the employee. Attach copy of employee signed participation application).

CLAIM NUMBER	CLAIMS EXAMINER	DATE