Death Claim Form

AFRICAN SURVIVOR BENEFIT FUND

Please post completed forms and documentation to:

Adventist Risk Management,® Inc.
12501 Old Columbia Pike, Silver Spring, MD 20904
Telephone: 1 (888) 951-4276, press 2 | **Fax:** (301) 453-7060
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. **African Survivor Benefit Fund #6105AFD**	**Address:** **12501 Old Columbia Pike, Silver Spring, MD 20904**
Name of Division:	Name of Employing Organisation:

Print Name of Authorised Employer:	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 (dd/mm/yy):
Int'l SB Effective Date (dd/mm/yy):	Change in Benefit Date (dd/mm/yy): 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**

- **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 doctors 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 provide 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 defences.

The undersigned hereby authorises all doctors, hospitals, pharmacists 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 authorisation is valid for the duration of this claim and that a photocopy of this authorisation shall be considered as valid as the original. I understand that I or my authorised representative may request a copy of this authorisation. 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)

(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