Global Basic Life Insurance

GBG Death Claim Form

Adventist Risk Management, Inc.
12501 Old Columbia Pike - Silver Spring, MD 20904
TELEPHONE: +1 (888) 951-4ARM (4276) | FAX: +1 (301) 453-7060 EMAIL:
claims@adventistrisk.org

How to File a Claim

1. Complete all of the sections of the claim form. Please include:
    - A medical cause of loss.
    - The primary beneficiary's signature.
    - Dates of birth for all listed beneficiaries.
    - The name of the employing organization.
    - The name, signature, and title of the Employer Representative.
2. Attach the following documents:
    - A copy of the beneficiary enrolment form.
    - Three consecutive, recent months of pay slips for the employee.
    - A death certificate.
    - Custodial affidavits for beneficiaries under the age of 18.
    - Copies of birth certificates for beneficiaries under the age of 18.
3. Send the completed and signed claim form and all required documents to:

Adventist Risk Management, Inc.
Claims and Legal Services
12501 Old Columbia Pike, Silver Spring, MD 20904
Email: claims@adventistrisk.org
Telephone: 1 (888) 951-4ARM (4276)
Fax: (301) 453-7060

4. Retain a copy for your records.

There are provisions, limitations, and exclusions in the policy.
GBG Insurance Company makes the final determination on payment or denial of all claims.

A CLAIM ADJUSTER WILL CONTACT YOU IF ADDITIONAL INFORMATION OR DOCUMENTATION IS REQUIRED.

DEATH CLAIM FORM

General Conference Corporation of Seventh-day Adventist – Policy #LIS-6497

Please post completed forms and documentation to:
Adventist Risk Management, Inc.
12501 Old Columbia Pike - Silver Spring, MD 20904
OFFICE: +1 (888) 951-4276 | **FAX:** +1 (301) 453-7060
EMAIL: claims@adventistrisk.org

By providing 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

Adventist Risk Management, Inc. **Global Basic Life**	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** Surname Name Middle Initial		Date of Birth (dd/mm/yy)	Place of Birth
Date of Hire (dd/mm/yy)	Social Security No. or ID No	Date Last Worked (dd/mm/yy)	Date Employment Terminated
Effective date of coverage (dd/mm/yy)	Place of Death	**Employee Benefit amount: USD:** **Spouse Benefit amount: USD:**	
Name of **DECEASED** Surname Name Middle Initial		Who died? □ Employee □ Spouse	**Date of Death** (dd/mm/yy)
Cause of Death (**Please attach death certificate**)		Occupation of **Employee**	**Full-time** □ **Weekly hours** **Part-time** □ __________

Name of Beneficiary(s)	Relationship to Deceased	Date of Birth dd/mm/yy	Beneficiary Signature	Percentage of Benefit
	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 Global Benefits Group, 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 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 defences.

The undersigned hereby authorizes all doctors, hospitals, druggists and employers to disclose to Adventist Risk Management, Inc and/or Global Benefits Group., its representative, and any and 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 authorisation 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)

(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