EMPLOYER’S NOTICE OF DEATH

Employer

Address of Employer

Employee Date of Birth

Social Security No.

Married Yes No

Sex Male Female

Occupation Status

(if leave of absence, retired or terminated, please give date) Active Leave of Absence Retired Terminated Date: Date Employed Date Employee insured with Employer Basic Optional If ever terminated & reinstated indicate new effective date: Basic Optional Employer last contributed to premium for month of:

Employee last contributed to premium for month of: Date of Death If death was due to an accident, was Employee working at the time of the accident? Yes No Date of Accident If death was due to an accident, please state how and where it occurred Name of Beneficiary Relationship to Deceased Date last worked Reason for leaving Amount of regular earnings for Employee at date of death

Annual $ Weekly $ Date of last change of earnings Class Effective Date for current insurance Amount of Basic Insurance Life Accidental Death Amount of Optional Insurance Life Accidental Death To Be Completed Only If Claim Is Being Made Under Dependent Coverage Dependent (Deceased) Date of Birth Social Security No. Relationship to Employee Address If claim for spouse, was he/she divorced or legally separated from the Employee? Yes No If claim for a child, indicate if single or married Was dependent employed? Yes No If Yes Full-time or Part-time If yes, please indicate the name and address of Employer If child was a college student, please indicate if full-time or part-time student and the name and address of the college Date Dependent insured with Employer Basic Optional If ever terminated & reinstated indicate new effective date Basic Optional Amount Basic Insurance Life Accidental Death Amount Optional Insurance Life Accidental Death