



Notice of Claim Proof of Dependent's Death

GE Financial Assurance
Employer Services Group

GE Group Life Assurance Company
PO Box 810
Greenfield, MA 01302-0810

TO: GROUP LIFE BENEFITS

Employer's Statement

Group Account Number	Name of Employee (Last, First, M.I.)	Date of Birth
Effective Date of Employee's Insurance	Amount of Employee's Insurance \$	
Effective Date of Dependent's Insurance	Amount of Dependent's Insurance - Basic \$	Supplemental Voluntary
Occupation of Employee	Basic Annual Earnings \$	Date of Employment
Was employee's premium, including premium for deceased dependent, paid and insurance in force on date of dependent's death? (If "No" give the date Coverage was terminated) <input type="checkbox"/> Yes <input type="checkbox"/> No		
What was employee's date of last service? (Month, Day, Year)		

It is certified that the statements contained above are true to the best of our knowledge and belief.

Signed by _____
Signature of Authorized Personnel Title Date Signed

Name of Employer Telephone Number

Employee's Statement

Name of Deceased Dependent (Last, First, M.I.)	Date of Birth	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
Relationship to Employee	Date of Death	Place of Death (City, State, Country)
Was this Dependent residing with you at time of death? (If "No", please give the dependent's address or explain) <input type="checkbox"/> Yes <input type="checkbox"/> No	If Dependent was hospital confined prior to death, please give date of last admission and name of hospital.	
Was this Dependent a full-time student at time of death? (If "Yes" give name and address of school attended.) <input type="checkbox"/> Yes <input type="checkbox"/> No	Was this Dependent hospital confined or totally disabled on the effective date of dependent coverage?	
Were you contributing more than 50% of any dependent's child support? <input type="checkbox"/> Yes <input type="checkbox"/> No	If this claim is for a spouse, please provide us with the date the dependent was last actively at work:	

I hereby certify that the answers in this statement are complete and true.

Signed by _____
Signature of Employee Date Signed

Address (No. and Street, City, State and Zip Code) _____

Proof of Death

A certified copy of Death Certificate from public records must be furnished as Proof of Death. Photocopies are NOT ACCEPTABLE. If on file at your office, please provide us with a copy of the employee's Enrollment Card and copies of any subsequent benefit election forms. If death was the result of an accident please provide us with copies of any applicable newspaper clippings.

State law, in some states, requires the following: A person commits a fraudulent insurance act, which is a crime, if he or she knowingly and with intent to defraud any insurance company, or other person, either: (1) Files a statement of Claim containing any materially false information; or (2) Conceals, for the purpose of misleading, information about any fact that is material to a claim. Violations are subject to criminal prosecution and may also result in civil penalties.