Protecting ADA Members
Since 1934

ADA Group Life Program
P.O. Box 1080
Denver, CO 80201
1-800-537-2033

## CLAIMANT'S STATEMENT

1. Particulars regarding the DECEASED:
   (a) Name (in full) ______________________
   (b) State of Legal Residence ______________ (c) Date of Birth ______________
   (d) Date of death ______________ (e) Place of death ______________
   (f) Name and address of each attending physician (if more space is required, please attach a separate sheet)
   1. ______________ 2. ______________
   (g) Duration of last illness ______________

2. Plan No. 104GP Certificate No. ______________.

   Amount Claimed:

3. Your full name is: (If beneficiary is a trust, please give the complete name and date of the trust)

4. Your relationship to deceased is:

5. What is your birth date?

6. In what capacity do you claim? (e.g. beneficiary, executor, assignee, trustee)

7. ☐ Check this box if claimant is not subject to back-up withholding under Section 340b(a)(1)(c) of the IRS Code. This information is required by the Internal Revenue Service.

8. Unless previously designated by the owner under an irrevocable option, as beneficiary do you wish the proceeds to be: (Check one or more, as applicable)

   ☐ Paid in a lump sum TOTAL AMOUNT PAYABLE (check payable to the beneficiary)

   ☐ Paid in installments $ ______________

   ☐ Placed on deposit $ ______________ Elect one of the following interest payment options. ☐ Monthly ☐ Qrtrly ☐ Semi-Ann. ☐ Annual

   Interest payment may not be accumulated except in cases of minor children.
   If you have any questions about the settlement options available, please call the company at the telephone number at the top of this form.

I hereby declare that the foregoing answers are true and full; that, to the best of my knowledge and belief, I have withheld no material facts from the Company and that the foregoing answers and statements are made with the object of securing payment to me of the proceeds of the above policy.

I expressly consent, authorize and direct any physician, surgeon, any law enforcement agency, or any other person who has examined or attended the deceased and every hospital or any other institution to which the deceased has applied for or in which the deceased has received treatment to disclose to the Company or its duly authorized representative any knowledge or information thereby acquired.

**NOTICE** – Filing a statement of claim containing any false, incomplete or misleading information with intent to defraud or deceive any insurance company is considered to be a felony in some states.

Date ______ Phone Number ( ) ______ Signature of Claimant ______________

Social Security or Tax Identification No.-See"D" on reverse side ______________ Printed Name of Claimant ______________

Street Address ______________

City ______ State ______ Zip Code ______

**SEE OTHER SIDE FOR HELPFUL DIRECTIONS FOR COMPLETING THIS FORM**

## A. WHO SHOULD COMPLETE THE CLAIMANT'S STATEMENT

1. **Where policy is payable to a named beneficiary –**
   The Claimant's Statement should be completed by the beneficiary except where a trustee was appointed by the deceased to act for her/him, or where he/she is a minor, or is otherwise unable to act for himself/herself.

   (a) *Trustee for beneficiary –*
   Where a trustee was appointed by the deceased to act for the beneficiary, whether the beneficiary be of age or not, the trustee should complete the statement.

   (b) *Minor beneficiary –*
   In certain States, a beneficiary who is 18 years of age may complete the Statement. Otherwise, where the beneficiary is a minor and no trustee has been appointed, the legal Guardian should complete the Statement and furnish a Court Certificate of his/her appointment. In some instances, the Official Guardian may act for a minor.

   (c) *Beneficiary under disability –*
   In the case of a beneficiary who is unable to act for himself, the Guardian should complete the Statement and furnish a Court certificate.

2. **Where policy is payable to the estate of the deceased –**
   The Claimant's Statement should be completed by the executors or administrators of the estate who should furnish a Court Certificate of their authority.

3. **Where there is more than one beneficiary –**
   A separate Claimant's Statement must be submitted by each.

## B. PROOF OF DEATH OF THE INSURED MUST BE SUBMITTED

Send a copy of the official death certificate.

## C. ACCIDENTAL DEATH

Submit details of the accident (newspaper clippings or police report). Additional information may be required, but this will be obtained directly from the authorities by Great-West Life & Annuity.

## D. FAILURE TO PROVIDE A SOCIAL SECURITY OR TAXPAYER INDENTIFICATION NUMBER MAY CAUSE WITHHOLDING OF A PORTION OF THE CLAIM PAYMENT IN ACCORDANCE WITH IRS REGULATIONS.

In issuing claim forms for the convenience of the claimant, the Company does not admit any liability or waive any of its rights.

Please feel free to ask Great-West for further information or assistance in completing the Proofs of Claim. We will be glad to do anything we can to help you, without charge.