Great-West Financial®
Underwriter of the ADA Members Insurance Plans

www.insurance.ada.org

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Denver, CO 80217
Phone 866-257-0707
Fax 303-737-2879

CLAIMANT'S STATEMENT – Plan 104GP

All fields must be completed. Missing fields will cause delays in handling.

1. Information regarding the DECEASED

   Full Name: _____

   Date of Birth: _____ Date of Death: _____

2. ADA/Certificate No. _____ Amount you are claiming: _____

3. Claimant's Full Name: _____
   Note - If beneficiary is a trust, please give the complete name and date of the trust.

4. Relationship to deceased: _____

5. What is your (the claimant's) date of birth: _____

6. In what capacity are you claiming (e.g. beneficiary, executor, assignee, trustee, etc.)?

   _____

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.

_____ _____
Printed Name of Claimant Signature of Claimant Date Signed

_____ _____
Social Security or Tax ID Number Street Address

_____
City State Zip Code

_____
Phone Number(s)

M1335 (Rev 12/14)