Attn: Sales Support
8220 Irving Rd.
Sterling Heights, MI 48312
586-693-4400

DEATH CLAIM FORM

USHL
US Health and Life

TO BE COMPLETED BY POLICYHOLDER (Employer)

POLICY IDENTIFICATION: This information must be completed to identify coverage.

Name of Employer _____ Policy (Group) No. _____

Address _____

Name of Employee _____ Certificate No. _____

Address _____

Employee's Social Security No. _____ Effective date of Insurance _____

Date Employed _____ Date Last Worked _____ Job Position _____

Enrolled Coverage: Life: Yes_____ No _____ AD&D: Yes_____ No_____ Amount of Insurance On Deceased _____

FULL NAME OF DECEASED	CLAIM IS FOR: Employee: ___ Dep.: Spouse___ Child ____	DATE OF BIRTH
RESIDENCE ADDRESS OF DECEASED		DECEASED SOCIAL SECURITY NUMBER
DATE OF DEATH	CAUSE OF DEATH Natural _____ Accident _____ Suicide _____ Homicide _____	PLACE OF BIRTH

MANNER OF DEATH: Natural ___ Accident _____ Suicide _____ Homicide_____

IF OTHER THAN NATURAL CAUSES, PROVIDE DETAILS:

_____

WAS DECEASED CONSIDERED AN EMPLOYEE ON DATE OF DEATH: YES__ NO ____

NAME OF BENEFICIARY (IES) – Attach Enrollment Card

NAME	RELATIONSHIP	AGE	ADDRESS

The statements above are true and complete. I/We agree that US Health and Life Insurance Company can rely on them as part of the Proof of Death under the Employee Group Life Insurance Policy.

_____ _____ _____
SIGNATURE OF AUTHORIZED REPRESENTATIVE TITLE DATE