



24950 Chagrin Blvd., Beachwood, Ohio 44122-5634

Phone: (216) 464-8015  
Toll Free: (800) 464-4642  
Fax: (216) 464-9260  
E-Mail: [info@fcscla.org](mailto:info@fcscla.org)  
[www.fcscla.org](http://www.fcscla.org)

## DEATH CLAIM REPORT

PLEASE LIST ALL INSURANCE CERTIFICATES OF THE DECEASED MEMBER

\_\_\_\_\_ Branch \_\_\_\_\_

### DECEASED MEMBER INFORMATION (Please PRINT using BLACK ink)

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Death \_\_\_\_\_  
\_\_\_\_\_ Date of Birth \_\_\_\_\_  
Age at Last Birthday \_\_\_\_\_

### BENEFICIARY INFORMATION (Please PRINT using BLACK ink)

Are Beneficiaries Living? \_\_\_\_\_ If not, attach photocopy of Death Certificate for each deceased Beneficiary.

**Please PRINT for each Beneficiary: (List additional Beneficiaries on separate sheet)**

Name: \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
\_\_\_\_\_ Relationship \_\_\_\_\_  
Social Security/Tax ID # \_\_\_\_\_ FCSLA Member? \_\_\_\_\_

Name: \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
\_\_\_\_\_ Relationship \_\_\_\_\_  
Social Security/Tax ID # \_\_\_\_\_ FCSLA Member? \_\_\_\_\_

Name: \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
\_\_\_\_\_ Relationship \_\_\_\_\_  
Social Security/Tax ID # \_\_\_\_\_ FCSLA Member? \_\_\_\_\_

### CONTACT PERSON

Name: \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_  
Address: \_\_\_\_\_ Relationship \_\_\_\_\_  
\_\_\_\_\_  
Signature of Contact Person Date

**A CERTIFIED DEATH CERTIFICATE & ORIGINAL POLICY/ CERTIFICATE(S) MUST ACCOMPANY THIS REPORT FORM.**

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Instructions for Completion of Death Claim:**

- A. List Certificate Numbers for all FCSLA policies/annuities held by the deceased insured.
- B. Complete all information concerning the insured.
- C. Complete all information for each Beneficiary. Failure to provide any of the requested information may delay payment of the claim.

**Claim must consist of the following papers:**

- \_\_\_ 1. Original Insurance Benefit Certificate (policy) or Statement of Lost Certificate form, (see below).
- \_\_\_ 2. This completed form.
- \_\_\_ 3. Certified Death Certificate for Insured member (Must have **original** certification).
- \_\_\_ 4. Any other forms or documents as requested by First Catholic Slovak Ladies Association.
- \_\_\_ 5. Death Certificates are required for any deceased designated beneficiaries (photocopies are acceptable). If all designated beneficiaries are deceased, benefits will be paid to the member's estate. If there is no estate please contact Death Claims Department for assistance.
- \_\_\_ 6. If Beneficiary is not of Legal Age, the check will be issued to the child in c/o Parent or Legal Guardian. Current certified copy of Guardian papers is required.



**First Catholic Slovak Ladies Association**  
**Claimant's Statement of Lost Certificate**  
 (For use with Death Claims Only)

**This section must be completely filled out and witnessed if original insurance policy(s) is missing**

I, \_\_\_\_\_ hereby state that I am the \_\_\_\_\_  
 (Name of Claimant) (Relationship)  
 of the deceased \_\_\_\_\_ who was a member of the First Catholic Slovak Ladies Association and the holder of certificate number(s) \_\_\_\_\_. That said certificate(s) is/are lost, and after diligent search cannot be found and, therefore, cannot be surrendered to the First Catholic Slovak Ladies Association. In the event the certificate is found, it shall be null and void for any purpose whatsoever.

\_\_\_\_\_  
 Claimant Signature Date

\_\_\_\_\_  
 Witness Signature Date



**BRANCH OFFICER CERTIFICATION**

We, the undersigned officers of Branch No. \_\_\_\_\_ of the First Catholic Slovak Ladies Association, certify that the deceased named was a member in good standing and premiums were paid in full, yes \_\_\_\_\_ no \_\_\_\_\_.

Amount due Branch Office \_\_\_\_\_

Name and Address of Branch \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Officer

\_\_\_\_\_  
Title