**Death Claims Department**
800.464.4642 x1063
lifeclaims@fcsla.com

# 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____________________

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

If designated beneficiary (s) is deceased, please attach photocopy of Death Certificate for each deceased Beneficiary.

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

Name: ________________________________________ Telephone # ( ) _________________

Address: ________________________________________ Date of Birth ____________________

________________________________________ Relationship to insured _________________

Social Security/Tax ID #______________________________

Name: ________________________________________ Telephone # ( ) _________________

Address: ________________________________________ Date of Birth ____________________

________________________________________ Relationship to insured _________________

Social Security/Tax ID #______________________________

Name: ________________________________________ Telephone # ( ) _________________

Address: ________________________________________ Date of Birth ____________________

________________________________________ Relationship to insured ________________

Social Security/Tax ID #_______________________________

**CONTACT PERSON - for claim information**

Name: ________________________________________ Telephone # ( ) ____________________

Address: ________________________________________ Relationship ____________________

________________________________________ ____________________________________

Signature of Contact Person Date

E-mail________________________________________

**AN ORIGIINAL 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 the completed Statement of Lost Certificate form, (see below).

___ 2. This completed claim report form.

___ 3. Certified Death Certificate for the Insured member (Must have **original** seal of certification).

___ 4. Any other supporting forms or documents as requested by First Catholic Slovak Ladies Association.

___ 5. Death Certificates are required for any deceased designated beneficiaries (photocopies are acceptable in this case). If all designated beneficiaries are deceased, benefits will be paid to the member's estate. If there is no estate being probated through the court, please contact Death Claims Department for assistance in completing the claim based on your state's rules.

___ 6. If the designated Beneficiary is not of Legal Age, the check will be issued to the child in c/o the court appointed Legal Guardian or Trust Account or UTMA bank account CUSTODIAN. A copy of Guardianship papers or proof of a trust/ UTMA account is required.

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## First Catholic Slovak Ladies Association Life
## 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 is missing.**

I, ______________________________ hereby state that I am the ______________________________
(Name of Claimant) (Relationship to insured)

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 later, it shall be destroyed.

______________________________ ____________________
Claimant Signature Date

______________________________ ____________________
Witness Signature Date

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