



District \_\_\_\_\_ Debit \_\_\_\_\_

**DEATH CLAIM FORM**

ADMINISTRATIVE OFFICES  
P. O. Box 506  
Keene, NH 03431-0506

POLICY NUMBER

**PLEASE PRINT (Failure to complete form will delay Claim Processing)**

A. NAME OF INSURED (Deceased)		Date of Death	
Address	Street Number	City	State Zip Code
Name of Beneficiary/Claimant		Social Security Number	Age Phone Number
Address	Street Number	City	State Zip Code Relationship to Insured

**B. If you are not the Beneficiary but are claiming the proceeds of the above policy(s) why do you believe you are entitled to the benefits? Please attach copies of any document that supports your claim.** \_\_\_\_\_

**C. If beneficiary is deceased, attach a certified certificate of death.**

**D. List Names of all Hospitals or Doctors and give location where any medical treatment or attention was received by Insured during the 5 year period prior to date of death. (If all policies are over 2 years in duration this section need not be completed.)**

HOSPITAL OR DOCTOR	STREET NUMBER	CITY	STATE	ZIP CODE

**E. Was Deceased in Armed Services during the last 5 years? YES  NO**

**F. Was deceased insured in any other company? Yes  No  If answer is yes, complete the following:**

Name Of Company	Amounts	Date

**G. Name of last employer** \_\_\_\_\_ **Address** \_\_\_\_\_ **Kind of business** \_\_\_\_\_

**H. Was deceased married? \_\_\_\_\_ If married, give full name and age of widow, if alive, and living children**

	Name	Age		Name	Age
Widow or Widower			Living Children		
Living Children			Living Children		

I/we hereby claim the proceeds of the policy listed above, and certify that the statement given herein are complete and true to the best of my/our knowledge and belief. I/we understand that the furnishing of forms by the company does not constitute an admission that there is any insurance in force. I/we hereby authorize all physicians, hospitals, clinics, or any other persons who have attended or treated the deceased to disclose any knowledge or information relating to the treatment or history of the deceased, and to permit the bearer, representing the NORTH CAROLINA MUTUAL LIFE INSURANCE COMPANY to obtain or view a copy of all records pertaining to such treatment or history. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ yr. \_\_\_\_\_  
 Signature of Claimant \_\_\_\_\_  
 Signature of other Claimant \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Social Security Number \_\_\_\_\_