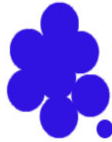
Great Lakes Employers Association



Group Marketing Services, Inc.

Group Insurance That Benefits Small Business

Group Life Insurance Claim Form
Employer Statement

Please send completed form and all attachments to:
P.O. Box 19040
Kalamazoo, MI 49019-0040

To avoid unnecessary delays, be sure all parts of the Claim Form are completed accordingly.

TO BE COMPLETED BY EMPLOYER/GROUP ADMINISTRATOR

Section 1: Employee Information

1. Employee Social Security Number
2. Name of Employee (Last, First M.I.)
3. Gender ☐Male ☐Female
4. Date of Birth
5. Date of Hire
6. Last Day Worked
7. Occupation
8. Phone Number
9. If not actively at work immediately prior to death, what was the reason? ☐Disability ☐Vacation ☐Leave of Absence ☐Temporary Layoff ☐Resigned ☐Retired ☐Discharged ☐Other:________________
10. Employee Address – Street Apt No. City State Zip
11. Work Classification ☐Hourly ☐Salary ☐Commission Only
12. Was coverage effective on date of death? ☐No, Explain why coverage terminated: ☐Yes

Section 2: Employer Information

13. Employer Name
14. Group Policy Number
15. Phone Number
16. Employer Address – Street City State Zip
17. Location name and address where employed
Location Name Street City State Zip

Section 3: Deceased Information

(3A) Complete if the deceased was the EMPLOYEE

18. Date of Death
20. Salary on last date worked $ per ☐Hour ☐Week ☐Month ☐Year
21. Marital Status ☐Single ☐Married ☐Divorced ☐Legally Separated
22. Disabled? ☐Yes ☐No
23. Occupational Death? ☐Yes ☐No
24. Insurance Classification
25. Cause of Death
26. Are Accidental Death Benefits Being Claimed? ☐No ☐Yes, Explain Accident:

(3B) Complete if the deceased was a DEPENDENT

27. Deceased Social Security No.
28. Deceased Name (Last, First M.I.)
29. Deceased Gender ☐Male ☐Female
30. Deceased Relationship to Employee ☐Spouse ☐Son ☐Daughter ☐Other:_______________
31. Date of Birth
32. Date of Death
33. Disabled? ☐Yes ☐No
34. Occupational Death ☐Yes ☐No
35. Effective date of dependent coverage
36. Cause of Death
37. Dependent's Marital Status ☐Single ☐Married ☐Divorced ☐Legally Separated
38. Was Dependent Employed? ☐Yes ☐No Name of Employer:
39. If dependent was 19 or over, was the dependent a full-time student? ☐Yes ☐No

Section 4: Employer Signature

40. Completed by (name of representative of the employer)

Print Name:______________________________ Signature:____________________________ Date:________________

Form 8971 - ERStmnt (Rev 3/1/07)