KJZT Family Life

Life Insurance Death Claim

INFORMATION ABOUT THE INSURED

Name of Deceased (Last, First, Middle Initial)	Certificate Number(s)

Deceased Date of Birth	Deceased SSN	Date of Death

Cause of Death

☐ Natural	☐ Accident	☐ Homicide	☐ Suicide

Name and Address of Primary or Family Physician

PLEASE NOTE:

(1) In addition to the above required information, a Certified Certificate of Death MUST be submitted.
(2) The insurance Certificate must accompany this claim.
If not available, please explain. ☐ Lost ☐ Destroyed
(3) The bottom portion of this form must be completed.
(4) If the Beneficiary is to the ESTATE, please submit Letters Testamentary.
(5) If the Beneficiary is a TRUST, please submit a Certification of Trust.

If claim is made within of two years of issue or for accidental death benefits, the undersigned hereby authorizes any physician, surgeon, technician and any public, private or government operated hospital or clinic including the Veterans Administration of the United States and any other agency, public or private, having information relating to the medical history, diagnosis, treatment or cause of death of the deceased to furnish the medical history, diagnosis, treatment or cause of death of the deceased to the Claims Department of KJZT Family Life, Austin, Texas with detailed information as it may request. A photocopy of this authorization shall be as valid as the original.

THE UNDERSIGNED DO HEREBY CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND CORRECT TO THE BEST OF MY (OUR) KNOWLEDGE.

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

P.O. Box 18896 ● Austin, Texas 78760 ● 512.444.9586 ● 1.888.253.2338

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INFORMATION ABOUT THE BENEFICIARY

Beneficiary Name(s)	Address	City, State, Zip	DOB	Relationship

CLAIMANT INFORMATION

Daytime Phone Number

Email Address

Printed Name

Relationship to Deceased

Claimant Signature

Date

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