KJZT Family Life
Faith · Community · Financial Security

KJZT Family Life
P.O. Box 18896, Austin, Texas 78760
(512) 444-9586 1-888-253-2338

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		**NAME AND ADDRESS OF PRIMARY OR FAMILY PHYSICIAN**
☐ NATURAL ☐ ACCIDENT	☐ SUICIDE ☐ HOMICIDE	

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 knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

INFORMATION ABOUT THE BENEFICIARY

NAME OF EACH BENEFICIARY	ADDRESS	CITY/STATE/ZIP	DOB	RELATIONSHIP	PAYMENT* (See below)
					☐ A or ☐ B
					☐ A or ☐ B
					☐ A or ☐ B
					☐ A or ☐ B
					☐ A or ☐ B
					☐ A or ☐ B
					☐ A or ☐ B

***Payment Instructions:**
A. Check Payable to Beneficiary **B.** Deposit into Checking Account (Complete Direct Deposit Form)

CLAIMANT INFORMATION

_____ _____
Daytime Phone Number Email Address

_____ _____
Printed Name Relationship to Deceased

_____ _____
Claimant Signature Date

KJZT Family Life

Life Insurance/Annuity/IRA Death Claim Direct Deposit Request Form

Certificate Number: _____

Deceased Member's Name: _____

Beneficiary Information:

Name: _____

Address: _____

Phone Number: _____

Bank Information:

Direct Deposit to my Bank (Direct Deposit information must be completed and include voided check OR a statement on your bank's letterhead with name and account information with this form).

Financial Institution Name: _____

Routing Number: _____

Account Number: _____

Address: (Street, City, State, Zip Code) _____

_____ _____

Signature of Beneficiary **Date**

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