blue of california

Proof of Death

Blue Shield of California Life & Health Insurance Company

P.O. Box 7725, San Francisco, CA 94120 1-888-800-2742

NOTE: Please complete the entire claim form. This form cannot be processed if information is incomplete. Please print using ink.

Section 1

Name of deceased	Social security no.	Date of birth
If dependent claim, name of employee	Social security no. of employee	Date of death

Amount of insurance being claimed (specify amounts claimed for Life, AD&D, Supplemental, etc.) ☐ Life _____ ☐ AD&D _____ ☐ Supplemental _____	Group policy no.	Effective date of employee's insurance

Job classification of employee	Monthly or annual salary (exclusive of overtime, bonuses, and other extra compensation) ☐ Monthly _____ ☐ Annual _____

Date of employees employment or date of union/association membership	Last month for which premium was paid for this employee or dependent	Date employee last reported for work

Reason for employee stopping work

Was life insurance in force at date of death? ☐ Yes ☐ No If not in force, date discontinued: _____	Did the employee have a waiver of premium (continued life insurance) claim with Blue Shield Life? ☐ Yes ☐ No

Date of last salary increase	Average hours worked	Amount of monthly premium paid	Settlement options ☐ Lump sum ☐ Installments

Section 2 Beneficiaries

Name	Social security no.		Date of birth	% of benefits
Address (number, street, apartment)	City	State	Zip code	Telephone no.
Name	Social security no.		Date of birth	% of benefits
Address (number, street, apartment)	City	State	Zip code	Telephone no.
Name	Social security no.		Date of birth	% of benefits
Address (number, street, apartment)	City	State	Zip code	Telephone no.

Section 3 Signatures

Remarks

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. Dated _____, 20 _____ Policy (Group) name _____

Important notice: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

Forms to be attached:

1. Original Enrollment Form, and Beneficiary Change Request forms (be sure to include all which pertain to this insurance.) (If dependent claim, enrollment form will be returned after a determination has been made on the claim.)
2. Certified Death Certificate (has the seal of the Health Department pressed into the paper, stamped in colored ink, or is printed on colored paper)
3. Photocopy of Dues Record if Union
4. Deceased's Certificate of Insurance (if available)
5. For AD&D claims: Newspaper clippings, coroner, toxicology and police/accident reports, and other information (if available) regarding the accident.

By _____
(signature of administrator of group)

_____
(please print administrator's name)

_____
Area code Phone number

_____
Address

Proof of Death *(continued)*

Special instructions

1. All death claims must be accompanied by an original certified death certificate listing manner and cause of death. A copy of a certified death certificate cannot be accepted.
2. If death resulted from anything other than natural causes (i.e. accident, homicide), a copy of the official investigative report (i.e. police, accident, fire, FAA, OSHA) must accompany or follow the claim. AD&D benefits cannot be paid on any claim without an investigative report regarding the insured person's/dependent's death. If your group contract contains an alcohol drug exclusion, a toxicology report will be required.
3. Groups must submit the enrollment form and copies of any beneficiary changes. If a beneficiary cannot be identified, benefits for the death of an Insured person will be paid to his or her estate.

If primary beneficiary has died

4. If the primary beneficiary is no longer living—a copy of the certified death certificate must accompany the claim before payment can be made to the contingent (secondary) beneficiary or to the estate. If the contingent (secondary) beneficiary is also deceased, a copy of that certified death certificate will also be required.

If there is no beneficiary

5. If no beneficiary is named, or if no beneficiary survives the insured person—payment will be made to the insured person's estate unless a preference beneficiary affidavit is completed.

If payment is to be made to an estate

6. Court documents of appointment must be forwarded to Blue Shield Life before payment can be made to the estate. The court documents must name the personal representative of the estate (called the executor, executrix, administrator or other court designated title) to whom benefits can be paid.

If payment is made to a trust

7. If payment is to be made to a trust, a copy of the trust document must be provided with the claim. Such documents should designate the trustee to whom proceeds will be paid.

If payment is in installments

8. All or part of the death benefit may be received in installments provided that the amount applied under a settlement option must be at least $10,000 and must be sufficient to provide a payment of at least $100 per month.

If beneficiary is a minor child

9. A minor lacks capacity to sign a binding release of an insurance contract. Only the lawfully appointed guardian/representative of a minor may give release for the payment to a minor. Life insurance benefits, therefore, cannot be paid to anyone who has not reached the age of majority. If guardianship documents are not secured, the proceeds will be held until the beneficiary reaches the age of majority, unless state statutes (i.e. the Uniform gifts/transfers to minors act) in the appropriate jurisdiction allow for other payment provisions to be used. Copies of such applicable statutes should accompany the claim.

ABU1180 (10/06) Reverse