



Lincoln Mutual
Life & Casualty Insurance Company

4510 13th Avenue South • P.O. Box 1918 • Fargo, North Dakota 58107-1918
Toll-free 1-800-233-6050

**STATEMENT OF DEATH (GROUP LIFE INSURANCE CLAIM FORM)
EMPLOYER'S STATEMENT**

This form should be completed by the employer upon the death of an insured employee and should be forwarded to above address. By furnishing this form and investigating the claim, the insurance company shall not be held to admit the validity of any claim or to waive or breach any condition of the policy.

EMPLOYER'S STATEMENT	1. Name of Employer		Group No.		
	2. Address				
	3. Name of Deceased Employee		Social Security No.	Date of Birth	
	4. Date Employed		Date on which insured last worked full-time		
	5. Reason for ceasing full-time employment on this date (death, disabled, laid off, etc.)				
	6. Date on which premium payment ceased			Amount of Insurance	
	7. Date of Death		Place of Death		
	8. Cause of Death		Was death due to accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	9. Name of Beneficiary		Relationship		
	If available, please include copy of last recorded beneficiary.				
	10. Age of Beneficiary, if minor		Address of Beneficiary		
11. Remarks:					
Name of authorized individual (Type or Print) _____					
Title or Position _____ Telephone _____					
Signature _____ Date _____					
<div style="display: flex; justify-content: space-around;"> Month Day Year </div>					

Any person who knowingly and with Intent to defraud or deceive an insurance company, files a statement of claim containing false, incomplete or misleading information, is in some states guilty of a felony.