



Lincoln Mutual
 Life & Casualty Insurance Company
 4510 13th Avenue South • P.O. Box 1918
 Fargo, North Dakota 58107-1918
 1-800-325-6915

Proof of Death

DEATH OF AN INSURED DEPENDENT

Important: Read Carefully

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a claim for insurance may be guilty of a crime and subject to fines and confinement in prison.

This form is to be completed upon the death of an insured and forwarded to Lincoln Mutual Life and Casualty Insurance Company. In addition, a certified copy of the original death certificate is required. If death was due to suicide, homicide or accidental means, a copy of the investigating officer's report is also required. By furnishing this form and investigating the claim, Lincoln Mutual Life and Casualty shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.

EMPLOYER'S STATEMENT

Group Number		Certificate/ ID Number	
Name of Employee		Date Employed	Date Last Worked
Name of Deceased Dependent		Date of Death	
Employer			Date
Signature			Title
Name (please print or type)			Telephone ()
Address		City, State, Zip	

EMPLOYEE'S STATEMENT

Deceased's Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Deceased's Date of Birth	Cause of Death
If relationship is shown to be "child," was deceased married at the time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If relationship is shown to be "spouse," was deceased married at the time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was the deceased a dependent and used by you as such for income tax purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you want dependent coverage cancelled? <input type="checkbox"/> Yes <input type="checkbox"/> No		

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to the deceased which may have a bearing on the benefits payable under this or any other plan providing benefits or services.

I certify that the information furnished in support of this claim is true and correct.

Date _____	Employee's Signature _____	Employee's Social Security # _____
Address _____	City, State, Zip _____	Daytime Telephone _____