MEDMUTUAL PROTECT®
A Medical Mutual® Company

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY

P.O. Box 14327, Reading, PA 19612
Telephone: 855-521-9345 Fax: 610-374-6986
Portal: https://medmutualprotect.loomislive.com

DEATH BENEFIT CLAIM FORM

Beneficiary Statement Instructions:

1. Please complete and sign Claimant's Statement. The beneficiary or claimant is to complete the Claimant's Statement. If more space is needed, please attach a separate piece of paper with the additional information.
2. If the policy is payable to the Estate or to the Executors or Administrators of the Insured, the Claimant's Statement should be executed by the Executor or Administrator. A certificate of appointment must be furnished.
3. If there are two or more beneficiaries, any one of them may complete the Claimant's Statement on behalf of all, in which case the full name, address, date of birth and social security number of each beneficiary is to be shown.
4. If the certificate is payable to a minor or a mentally incompetent person, a guardian should complete the statement, a certified copy of appointment must be provided.
5. Please provide a CERTIFIED COPY OF THE DEATH CERTIFICATE, indicating the cause of death. A certified copy of the death certificate of any deceased beneficiary must also be furnished.
6. If cause of death is due to an injury or accident, please provide a copy of the police report and and/or newspaper articles concerning the death.
7. Employer's Statement portion must be signed and completed by an authorized representative of the employer of the policyholder.
8. Please include a photocopy of the Insured's Enrollment Form.

Insured/Claimant Statement

Deceased's Full Name	Policy/Certificate #	Social Security No.	Date of Birth	Sex

Deceased's Address (Street, City, State, Zip)	Place of death

Beneficiary's Full Name	Beneficiary's Social Security No.	Beneficiary's Date of Birth

Beneficiary's Daytime Phone Number	Beneficiary's Address

Names of all physicians or practitioners who attended the deceased within five years preceding death. *(attach additional sheet if needed)*

Names	Addresses	Dates of Attendance	Diseases/Conditions
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate any other policies with this company:

_____

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICAN OR OTHER PROVIDER, INSURER OR OTHER THIRD-PARTY PAYER OR THE MEDICAL INFORMATION BUREAU TO FURNISH TO RESERVE NATIONAL INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA, OR ITS REPRESENTATIVE, OR PERMIT SAID INSURANCE COMPANY, OR ITS REPRESENTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINIAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Claimant/Beneficiary's Signature:_____ Date_____

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Employer's Statement

Deceased's Full Name:	Employee's Name:	Group Policy #:	Employee's Social Security No.:
Name of Company:			Employee was: Salaried Hourly
Date Insured/Employee	Date Insured/Dependent	Date of Hire	Did injury occur on duty? Yes No
Cause of Death	Date and Time of Death	Amount of Insurance	Amount of Claim
Was premium paid and insurance in force at the time of loss? Yes No			
Printed Name of Authorized Representative: _____	Signature of Authorized Representative: _____	Title: _____	
Date: _____	Phone Number: _____	Fax Number: _____	