PACIFIC GUARDIAN LIFE

GROUP LIFE CLAIM FORM

By furnishing this blank form and investigating the claim, the Company shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.

INSTRUCTIONS

At the death of an insured employee or member (or of a covered dependent), fully completed Group Life claim form, the insurance Certificate of Coverage, an original Death Certificate and the original Enrollment Card and all Change of Beneficiary forms should be sent to:

Pacific Guardian Life
Group Claims Department
1440 Kapiolani Blvd., Ste 1700
Honolulu, HI 96814

If the insurance proceeds are payable to the Estate of the Insured, a certificate showing the appointment of the Administrator or Executor of the Estate must be furnished.

If the insurance proceeds are payable to a minor or mentally incompetent person a certificate showing the appointment of the Guardian of the Estate of the minor nor mentally incompetent person must be furnished.

If the designated beneficiary is deceased, a certified copy of the deceased beneficiary Death Certificate must be furnished.

TO BE COMPLETED BY EMPLOYER OR GROUP TRUST ADMINISTRATOR

1. Name of Insured: Social Security Number:
2. Date of Birth: Date of Death:
3. Cause of Death: Place of Death:
4. Death due to occupational accident? ☐ Yes ☐ No Effective Date of Coverage:
5. Date employed: Date employed full-time:
6. Date Insured last worked full-time: No. of hours worked per week:
7. Date employment terminated: Reason:
8. Date Insured's premiums are paid to: Salary: $
9. Insured's occupation:

FOR DEPENDENT CLAIM ONLY:

Dependent's Name: Social Security Number:

Date of Birth: Relationship to Insured:

10. **AMOUNT OF INSURANCE**
    a. Life Amount: $ c. Accidental Death Benefit: $
    b. Supplemental Amount: $ d. Dependent Life Amount: $
11. **BENEFICIARY'S INFORMATION (use back of form for additional beneficiary designations)**
    Name: Date of Birth:
    Street Address:
    City: State: Zip:
12. Social Security Number: Telephone:
13. Relationship to Insured:
14. **EMPLOYER OR GROUP TRUST INFORMATION (please print or type)**
    Name: Policy Number:
    Address (Street, City, State, Zip): Telephone Number:
    Authorized Representative:

Signature of Authorized Representative: **Date:**

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