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www.suttonspecialrisk.com

SUTTON
SPECIAL RISK

PROOF OF DEATH

EMPLOYER'S STATEMENT

PLEASE ATTACH:

☐ Photocopy of employee enrollment card or proof of enrollment.

☐ Verification of premium deduction

Policyholders name	Policy No.
Full name of Employee	
Date insured (employee coverage) Month Day Year	Date insured (dependent coverage) Month Day Year
Was premium paid and coverage in force at the time of the accident?	◯Yes ◯No
Amount of Insurance $	Amount of Claim $

Dated at this day 20

Signature Official Position

CLAIMANT'S STATEMENT

PLEASE ATTACH:

Certified copy of Death Certificate

Copy of newspaper clipping, police report or Coroner's report

Proof of marital status or dependent eligibility

DETAILS OF ACCIDENT

Date and time of Accident? Month Day Year ◯am ◯pm	Did accident occur on duty? ◯Yes ◯No

Please explain details of accident fully.

A. DEPENDENT CLAIM / TO BE COMPLETED BY EMPLOYEE

Name of dependent	
Date of Birth Month Day Year	Relationship to Insured
Was deceased entirely dependent on you?	Yes/Give details No/List last place of employment

Employee Signature Witness Date

B. INSURED CLAIM / TO BE COMPLETED BY BENEFICIARY

Name of Beneficiary	Relationship to Insured
Address:	

WAIVER OF PRIVILEGED COMMUNICATION

I hereby authorize and request that you furnish Sutton Special Risk Inc., or its representative, with all the facts and dates which may be desired in reference to this claim. I further authorize Sutton Special Risk Inc., or its representative, to obtain, at its expense, copies of any and all portions of the records concerning the physical and medical history of

_____, deceased.

I UNDERSTAND the information obtained by use of the Authorization will be used by Sutton Special Risk Inc., to determine eligibility for coverage or eligibility for benefits under existing coverage. Any information obtained will not be released by Sutton Special Risk Inc., to any person or organization EXCEPT to the Insurer, or other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required, or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be valid as the original. I AGREE this Authorization shall be valid for two years from the date shown below.

Beneficiary Signature Witness Date