CUNA CARIBBEAN INSURANCE

# THE FAMILY INDEMNITY PLAN

## CLAIM STATEMENT

(TO BE COMPLETED BY CLAIM REVIEWER ONLY)

CLAIM NUMBER ___________________

DATE RECEIVED ______/_______/_______

Complete this form in **full** and attach a Death Certificate **or** Proof of Death Form.

**MEMBER'S NAME**: ________________________________ **CERTIFICATE NO.** ________________________________

**NAME OF DECEASED**: _____________________________ **RELATIONSHIP TO MEMBER** _____________________

**DATE OF BIRTH:** _______/_______/_________
DD / MM / YYYY

**DATE OF DEATH:** ________/________/__________
DD / MM / YYYY

________________________________________________________________________________________________

**DECEASED'S USUAL DUTIES OF LIVELIHOOD (i.e. Fireman, Laborer, etc.)**

**WAS DEATH ACCIDENTAL?** ☐ YES ☐ NO

**CAUSE OF DEATH**: ________________________________________________________________________________

**PLANTYPE:** ☐ **A** ☐ **B** ☐ **C** ☐ **D** ☐ **E** ☐ **F**

**CERTIFICATE EFFECTIVE DATE**: ___________________ **AMOUNT BEING CLAIMED** $_______________________

**CERTIFICATE OF ORGANIZATION**

I hereby certify that the above named deceased was insured under the Family Indemnity Plan Policy No. ________________, Certificate No._______________ with this Organization, that the above information is true and correct, **premiums have been paid,** and any facts not revealed above are explained in the REMARKS section below.

The Office that administers this Program is hereby released with respect to payments made on behalf of the above insured person.

Organization Name: ________________________________________________ Telephone _______________________

Address ___________________________________________________________________________________

Name of Organization Officer__________________________________ Position/Title _____________________________

Signature of Authorized Organization Officer______________________________ Date: ___________________________

**REMARKS**

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A member of CUNA MUTUAL GROUP