DEATH CLAIM
INSURED INFORMAION

Full Name of Deceased: _____

Policy Number: _____ Date of Birth: _____

Date of Death: _____

Death Certificate: ❑ Attached ❑ Ordered ___/___/____
❑ Pending Autopsy ___/___/_____

Beneficiary/Claimant Full Name: _____

Address: _____

_____

Phone Number: _____ ❑ Mobile ❑ Business ❑ Home

Email Address: _____

Relationship: _____

For additional beneficiaries please provide the above information on a separate page.

Primary Physician: _____

Address: _____

Phone Number: _____

Specialist: _____

Address: _____

Phone Number: _____

Additional comments: _____

_____

Send completed form to 6911 North RR 620, Ste A-300, Austin, TX 78732, ATTN: Death Claims, or email to admin@securicolife.com

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Company Use Only

Date Claim Received: ___/___/____ Date Death Certificate Received: ___/___/____

APS Ordered ❑ Yes ❑ No Date APS Received: ___/___/____