SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
607.723.3551 • www.smlny.com

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Mail completed form to:
Group Claims
Security Mutual Life Insurance Company of New York
PO Box 1625 • Binghamton, NY 13902-1625

EMPLOYER'S STATEMENT

GROUP LIFE INSURANCE DEATH CLAIM FORM
TO BE COMPLETED IN FULL BY THE EMPLOYER

Employee's name: _____ Policy Number: _____

Address: _____
Number Street City State Zip Code

Date of Birth: _____ (mm/dd/yyyy) Date of Death: _____ (mm/dd/yyyy) Social Security Number: _____

Date of Employment: _____ (mm/dd/yyyy) Last Day Actively at Work: _____ (mm/dd/yyyy) Employee's Job Title: _____

Was employment terminated prior to death? ☐ Yes ☐ No If "Yes", effective date of termination _____ (mm/dd/yyyy)

Reason for leaving work: ☐ Disability ☐ Lay-off ☐ Dismissed ☐ Resigned ☐ Leave of Absence ☐ Retired
☐ Other – state reason _____

Over the past 26 weeks, average number of hours worked per week: _____

Base annual compensation; Do not include bonuses, overtime, etc (Please refer to your Group Policy for a definition): $ _____

Effective Date of Coverage: _____ Amount of Insurance $_____

DEPENDENT COVERAGE – Complete only if claim is for a covered dependent

Dependent's Name: _____ Dependent's Social Security Number: _____

Dependent's Date of Birth: _____ (mm/dd/yyyy) Dependent's Date of Death: _____ (mm/dd/yyyy) Relationship to Employee: _____

BENEFICIARY INFORMATION – If more than one beneficiary is named, attach a separate sheet with the requested information for each named beneficiary.

Name of Beneficiary: _____

Address: _____
Number Street City State Zip Code

Beneficiary's Relationship to Deceased: _____ Beneficiary's Date of Birth: _____ (mm/dd/yyyy)

Mail Beneficiary's checks to ☐ Employer or ☐ Beneficiary (if no selection made, death proceeds check(s), will be mailed to the Employer).

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

Date Signed: _____ Group ID No.: _____

Employer's name: _____

Complete business address: _____
Number Street City State Zip Code

Signature of person completing this form: _____

Print name and title of person completing this form: _____

Employer's Telephone Number: _____ Employer's Fax Number: _____

Employer's Email address of Individual completing this form: _____

For assistance in completing this form, please call the Group Claims unit at 1-800-382-6400.

Clear Form