The Family Indemnity Plan

CLAIM STATEMENT

CLAIM NUMBER _____

DATE RECEIVED _____
(TO BE COMPLETED BY CLAIMS REVIEWER ONLY)

Complete in detail Parts I, II and III of this form and forward with a Death Certificate or Proof of Death Form.

PART I

DATE MAILED:

_____
Member's Name Last First

_____
Member's Certificate Number

_____
Deceased's Name Relationship to the Member

_____
Deceased's Date of Birth Day Month Year Age

_____
Deceased's Date of Death Day Month Year

_____
Deceased's Usual Duties of Livelihood (i.e. Fireman, Laborer, etc.)

Was death accidental? Yes ☐ No ☐

Cause of Death: _____

PART II

Plan A ☐ B ☐ C ☐ D ☐ E ☐ F ☐

Plan effective date: _____

Amount claimed based on the Plan Coverage Amount : _____

PART III

_____
Full Name of Organization Policy Number

_____
Mailing Address Number and Street City Country

_____ _____ _____
Telephone Number Organization Hours Signature Title

(Mr., Mrs., Miss, Ms.) _____
Print or Type Name of Above

I hereby certify the above information is true and correct, **premium has 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.

REMARKS

CUNA MUTUAL GROUP
CMFG Life Insurance Company