Death Claim – Employer Statement

CLEAR FORM

1. Employee information

Clear Section

Name (First/Middle/Last):	
DOB (dd-mmm-yyyy):	Certificate number:

2. Employer information

Clear Section

Employer name:	Policy number:
Representative (First/Middle/Last):	Title:
Phone:	Email:

3. Employment and benefit information

Clear Section

Employment date (dd-mmm-yyyy):	Effective date of coverage (dd-mmm-yyyy):
Employment status: ☐ Active employee ☐ Retiree If retiree, please provide retirement date (dd-mmm-yyyy):	
Benefit class: ☐ Employee ☐ Management ☐ Executive	Occupation:
Amount of insurance $	Date of last increase in insurance (dd-mmm-yyyy):
Annual salary on last working day (excluding bonus, overtime, and special compensation) $	

4. Claim information

Clear Section

Was death due to: ☐ Suicide* ☐ Homicide* ☐ Accident* ☐ Medical condition ☐ Other:*

Date of death (dd-mmm-yyyy):	Last date worked (dd-mmm-yyyy):

Was death a result of a work-related accident?* ☐ Yes ☐ No

If yes, is claim being made for Worker's Compensation? ☐ Yes ☐ No

Was the employee travelling on company business at the time of the incident? ☐ Yes ☐ No

If work-related accident, please provide details:

Location of accident:

Additional information:

** Please provide a copy of the Accident Report, Employer's Accident Report and/or Police Report (if applicable).*

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5. Beneficiary information

Beneficiary 1

Clear Section

Name (First/Middle/Last): Gender: ☐ Male ☐ Female

DOB (dd-mmm-yyyy): Relationship to deceased: Nationality:

Residential address:

Phone: H W C Email:

Beneficiary 2

Clear Section

Name (First/Middle/Last): Gender: ☐ Male ☐ Female

DOB (dd-mmm-yyyy): Relationship to deceased: Nationality:

Residential address:

Phone: H W C Email:

Beneficiary 3

Clear Section

Name (First/Middle/Last): Gender: ☐ Male ☐ Female

DOB (dd-mmm-yyyy): Relationship to deceased: Nationality:

Residential address:

Phone: H W C Email:

Beneficiary 4

Clear Section

Name (First/Middle/Last): Gender: ☐ Male ☐ Female

DOB (dd-mmm-yyyy): Relationship to deceased: Nationality:

Residential address:

Phone: H W C Email:

Declaration

Employer declaration and signature

By signing this form, I confirm/understand that:

- *The furnishing of forms by BF&M does not constitute an admission that there is any assurance in force.*
- *The information provided above is true and complete and I confirm that the insured identified in Section 1 was eligible and insured under the provision of the Master Policy.*
- *A photocopy of this authorisation is as valid as the original.*

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Declaration (cont'd)

Data protection declaration

By signing this form, I confirm/understand that:

- *I have obtained the insured's consent to enable the lawful transfer of their personal data to BF&M for the processing purposes described in BF&M's Privacy Policy (www.bfm.bm/privacy).*

I submit this application and fully understand that by checking the "ACCEPT TERMS" box below, I confirm that I (in my capacity as Employer) understand and agree with the declaration set out above.

☐ **ACCEPT TERMS**

Name:	
Sign:	Date (dd-mmm-yyyy):

Instructions

1. Submit completed Attending Physician's Form
2. Submit completed Employer Statement Form (this form)
3. Submit completed Claimant / Beneficiary Statement Form
4. Submit the Accident Report, Employer's Accident Report and/or Police Report (if applicable)

For BF&M official use only

Reports submitted: ☐ Accident Report ☐ Employer's Accident Report ☐ Police Report (required)

Date processed: ____/____/____ Admin: _____ Comments: _____