

**MUNICIPAL EMPLOYEES GROUP INSURANCE PLAN
NOTICE OF INSURANCE COVERAGE AT DATE OF DEATH**

Employer Number: _____ Employer Name: _____

Employee Name: _____ S.I.N.: _____

This form is to be used to report the death of an employee or an employees' family member.

Name of Deceased: _____

Date of Birth of Deceased: _____ Date of Death: _____
(ddmmmyyyy) (ddmmmyyyy)

Name & Address of Contact Person: _____

Phone Number of Contact Person: _____

Relationship to the Member: _____

Was death a result of an accident? Yes No Unknown

Member's occupation at date of death: _____

Complete for Full-time Permanent Employees only:

Current Annual Earnings Rate at date of death: \$ _____ Effective Date _____

Employee Insurance Contribution(s)

Basic Life \$ _____ Optional Life \$ _____ Family Life \$ _____

Voluntary Accidental Death & Dismemberment \$ _____

Contribution Frequency: Weekly Bi-weekly Semi-Monthly Monthly

Did this employee pay all required contributions for insurance coverage up to and including the date of death? Yes No

Amount of Insurance

Basic Life Insurance \$ _____

Optional Life Insurance \$ _____

Voluntary Accidental Death & Dismember Insurance \$ _____

Employee Only Plan Employee & Family Plan

Family Life Insurance Yes No

Was the employee on lay off or leave of absence at the time of death? Yes No
(If "Yes", enclose a copy of the most recent Group Insurance Plan Lay off/Leave of Absence Form #44). Also, please complete and enclose a Separation Notice (**Form #10**)

Date

Authorized Officer's Signature

Phone

Name of Authorized Person