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 employee's 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: _____

Last Physical Day at Work: _____

Complete for Full-time Permanent Employees only:

Annual Salary or Hourly 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 Coverage

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

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