AFA VETERAN BENEFITS ASSOCIATION
ACCIDENTAL DEATH INSURANCE
CLAIM FORM

NOTE: A CERTIFIED COPY OF DEATH CERTIFICATE MUST BE FURNISHED WITH THIS COMPLETED FORM

STATEMENT OF BENEFICIARY OR OTHER CLAIMANT

1. Your full name ________________ 2. Your age ________
3. Your relationship to decedent ________________
4. Full name of decedent ________________ 5. Decedent's date of birth ________
6. Last legal address of decedent ________________
7. Date of accident ________________
8. How did the injury occur? ________________
9. What injury or injuries were received? ________________
10. Who was present when the decedent was injured? (Give full names and addresses) ________________

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11. Was an inquest held? ________ (If so, attach a certified copy of the testimony taken and verdict of the jury.)
12. Was an autopsy held? ________ (If so, attach a copy of the report.)
13. State name and address of the doctor first contacted after injury and the name of the doctor who attended decedent at time of death.

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14. Was decedent sick from any cause within five years preceding death? ________________
If so, state the name of the disease and the name and address of the physician who attended him or her:

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15. Did decedent carry any other accident, health or life insurance? ________________
If so, the name of the company and type of insurance ________________

AUTHORIZATION TO RELEASE CLAIM INFORMATION
TO METROPOLITAN LIFE INSURANCE COMPANY

Policy No. 4606-G1

To Any: Physician, hospital, pharmacist or other provider of health care services, insurer, employer, group policyholder, government Agency, consumer reporting agency, acquaintance, policy or benefit plan administrator:

You may give Metropolitan Life Insurance Co. information about ________________ 's health or work status. You may also give this information on MetLife's behalf to: (a) the claim investigation department of a consumer reporting agency, or (b) the claim department of a policy or benefit plan administrator. Health information means all information about: (1) physical or mental condition, and (2) medical treatment and supplies, if needed to evaluate this claim. This information will be used to evaluate this claim for death benefits. This form will be valid for the duration of this claim. A photocopy of this form is as valid as the original.

Date ________________ Signature ________________ Relationship ________________

SS# ________________ Your Address: ________________

STATEMENT OF ATTENDING PHYSICIAN

1. Name of decedent ______________________________
2. How long have you known decedent? ______________________________
3. Where and when did you first attend decedent? ______________________________
4. Was decedent hospitalized? __________ Name of hospital ______________________________
5. Describe decedent's condition on your first visit ______________________________
6. Were there any symptoms or signs of disease? Yes No If "Yes," describe ______________________________
7. Date of accident ______________________________
8. Were there any visible contusions or wounds on the body of decedent? ______________________________
9. Nature and extent of the injuries ______________________________
10. Date of death ______________________________
11. Primary cause of death ______________________________
12. Did any disease or cause, other than the injury referred to, complicate or contribute to the cause of death? __________

    If so, what? ______________________________
13. Was the injury described above, independently of all other causes, sufficient to cause death? __________
14. If a postmortem examination was made, what were the findings as to cause of death? __________
15. Give names and addresses of other physicians or surgeons, if any, who attended decedent after the injury__________

Date __________ Attending Physician Sign Here ______________________________

Street Address ____________________ City __________ State ______ Zip __________

NOTE: ATTACH ORIGINAL POLICY CERTIFICATE AND BENEFICIARY CHANGES.

AFA VETERAN BENEFITS ASSOCIATION STATEMENT

FOR AFAVBA USE ONLY

1. Full Name of Decedent ____________________ SS# __________ Eff date __________
2. Name of beneficiary shown on AFAVBA records ____________________ Relationship __________

We hereby certify that, to the best of our knowledge and belief, the above statements are correct and that said decedent's insurance was in force on the date of his/her death for the amount of $__________

Master Policy No: 4606-G1 Master Policyholder: AFAVeteran Benefits Association

Date: ____________________ By: ______________________________

AFAVBA Authorized Staff Representative