Norhtern MN-WI Area Retail Food Health & Welfare Fund

Death Benefit Claim Form

This form should be completed by the claimant upon the death of an insured employee a (active or retired), and should be forwarded along with a **Certified Copy of the Death Certificate** to:

Northern MN-WI Area Retail Food Health & Welfare Fund
2002 London Road – Suite 300
Duluth, MN 55812
(218) 728-4231 | (800) 570-1012

If death was due to suicide, homicide or accidental means, please also furnish a coroner's report and/or a copy of the investigating officer's report, if available.

By furnishing this form and investigating the claim, the insurance company shall not be held to admit the validity of any claim or to waive or breach any condition of the policy.

CLAIMANT'S STATEMENT

Name of Insured: _____

Social Security Number of Insured: _____

Date of Birth: _____ Date of Death: _____

Claimant's Name: _____

Claimant's Social Security Number: _____

Claimant's Date of Birth: _____

Relationship to Deceased: _____

Claimant's Current Address: _____

_____

Claimant's Signature: _____
(If age 18 or older)

Legal Guardian's Signature: _____
(If claimant is under age 18)

Date Signed: _____