BLUEBONNET LIFE INSURANCE COMPANY

EMPLOYER: MAIL COMPLETED FORM TO:

P.O. Box 22924 • Jackson, MS 39225-2924

APPLICATION FOR GROUP LIFE INSURANCE PROCEEDS

Failure to complete it may cause unnecessary delay.

EMPLOYER'S CERTIFICATION

This is to certify that the facts as indicated below are true to the best of my knowledge and belief.

Name of Employee	(First Name)	(Middle Initial)	(Last)

Residence address	(Street)	(City)	(State)	(ZIP Code)

Group/Policy Number	Contract/Certificate Number	Category of Insurance	Amount of Insurance
Date of Employment	Date of Last Active Service	Basic	
Was above considered an employee until date of death?		Additional	
If employee terminated give reason and date.		AD&D	
Employee's Job Title			

If employee's termination was due to disability give summary of his activities since termination.

Effective Date of Insurance	Date of Last Benefit Increase	Basic Annual Earnings	Date of Birth	Date of Death	Hrs. Worked Wkly.

Beneficiary's Full Name	Beneficiary's Relationship to Deceased	Beneficiary's Soc. Sec. No.	Beneficiary's Date of Birth

Address of Beneficiary	(Street)	(City)	(State)	(ZIP Code)

Has an assignment been taken? ☐ Yes; ☐ No. If yes, please attach.	Resident State of Beneficiary

Complete the next two lines if insured is a dependent.

Name of insured deceased	Relationship to Employee

Effective date of insurance	Date of Birth	Married Yes ☐ No ☐	Occupation

Date Signed (Mo.) (Day) (Yr.)	Name of employing company	Signature of authorized representative

PHYSICIAN'S CERTIFICATION

Note: This is to be furnished without expense to Bluebonnet Life Insurance Company. The medical certification follows the recommendations of the World Health Assembly made in Geneva on July 24, 1948. It has been accepted by all States in this country and in Canada. It may be omitted if Death Certificate or copy of coroner's findings is substituted. In the interest of accurate vital statistics, please conform to the International List of the Cause of Death.

Full name of deceased	Age at Death or Date of Birth

Cause of death (Enter only one cause for each of a, b and c.)	Interval between onset and death
Disease or condition directly leading to death: (This does not mean the mode of dying such as heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	
(a)	(a)
Antecedent causes: (Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last).	
Due to (b)	(b)
Due to (c)	(c)
Other significant conditions: (Contributing to the death but not related to the disease or condition causing death.)	

Date of Death	Date of First Attendance in Last Illness	Date of Last Attendance In Last Illness

Did the deceased receive treatment during the last 5 years from any other physician? ☐ Yes; ☐ No.	If yes, Name of Physician	Address

Dated	Address	(City)	(State)	Signature of physician

The issuance of this blank is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights in the premises.