GMP Member Death Benefit Fund – Claimant Statement

608 E. Baltimore Pike, Media PA 19063 – P: (610) 565-5051

Notice is hereby given to the Death Beneficiary Department that the member named below died and the undersigned submits proof of claim by the following answers and statements:

Claimant Complete this Section Regarding Deceased

Deceased Full Name | Date of Birth

Social Security Number | Date of Death

Claimant Complete this Section

I am making this claim for the payment as (check one):

	Named Beneficiary		Surviving Lawful Spouse		Surviving Child		Executor/Administrator

Name | Relation to Deceased

Address | City, State & Zip

Date of Birth | Social Security Number

Phone #

The following must be attached:

1. Original Death Certificate for Deceased
2. Completed W-9 Form to include beneficiaries SSN or EIN of the Estate and Signature
3. If submitting claim for other than named beneficiary, supporting documents (marriage certificates, birth certificates, etc.) and if required the Surviving Child Affidavit and photocopy of the named beneficiary's death certificate.

I make the above statement believing them to be true and complete according to the best of my knowledge and request the Death Beneficiary Department to pay the Death Benefit to me.

Date | Signature of Claimant

Do Not Complete This Portion

Date of Payment: | Amount Paid $:

Processed By: | Claim Number:

Vendor #: