

# Notification of Death Group Life

Name of employer or pension fund: \_\_\_\_\_

## 1. Information about the insured deceased person

Policy No.

Insured No.

Last name

First name

Street/No.

ZIP code, City/Town

Marital status

single    married    widowed    divorced    registered partnership    partnership

Date of birth: Day   Month   Year  
     

Date of death: Day   Month   Year  
     

Cause of death:  
 Illness    Accident

Was the deceased person incapable of work or disabled three months or longer before death?    yes    no

## 2. Doctors' addresses

First doctor to give treatment or hospital/clinic

  
  

Doctor giving follow-up treatment or hospital/clinic

  
  

## 3. Employer's comments

  
  

Location

Date: Day   Month   Year  
     

**Submit**