City of Detroit

EMPLOYEES BENEFIT PLAN

PROOFS OF DEATH – CLAIMANT'S STATEMENT

This statement must be sworn to before an officer authorized to administer oaths.

Deceased's name in full ______________________________ Social Security Number ________________

Last residence address of deceased ____

City ______________________ State ______________ Zip ______________

Deceased's date of birth ____________________ Place of birth ______________________________

Was deceased employed by the City of Detroit at the time of his/her death? ______________________

City Department last employed in ______________________ Occupation ______________________

Date of Death ____________________ Place of Death ______________________________________

Address ____

City ______________________ State ______________ Zip ______________

The undersigned hereby makes claim to benefits in the City of Detroit Employees Benefit Plan and agrees that the written statements and affidavits of all physicians who attended or treated the member shall constitute and are hereby made a part of these proofs of death and further agrees that the furnishing of this form or other forms supplemental thereto by the Benefit Plan is not to be considered as nor constitute an admission of liability by the City of Detroit Employees Benefit Plan.

Dated at ____________________________ This__________Day of ____________________20________

Signature of Claimant____

Print Name of Claimant ____

Claimant's Residence Address ____

City ______________ State ______________ Zip ______________ Phone ______________

On this ____________day of ________________, 20_____ personally appeared the above-named and made oath that the answers by him/her above-made and subscribed are true and full to the best of his/her knowledge and belief.

State of ____________________

County of ____________________

____
Notary Public

My Commission expires ____________________

(seal)