

# 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

Signature of the employer/of the pension fund  
(Your signature is only required if you do not send us this form electronically but by mail.)

Date: Day  Month  Year

\_\_\_\_\_

Please send this form directly to: Zurich Switzerland, Group Life Benefits, P.O. Box, 8085 Zurich  
or by E-Mail to: [Leistungen\\_KL\\_Tod@zurich.ch](mailto:Leistungen_KL_Tod@zurich.ch)