STATE OF COLORADO
LIFE / AD&D INFORMANT'S FORM

EMPLOYEE INFORMATION

Name: ______________________________ SSN: ______________

Job Title: ______________________ Original Date of Hire: ____________

Last Payroll Deduction: ______________ Annual Salary as of July 1: __________

Date Last Worked: __________ Reason Empl Stopped Working: ________________

CLAIMANTS PERSON'S INFORMATION

Name: ______________________________ SSN: ______________

Date of Birth: ____________ Date of Death or Dismemberment: ____________

Was the death or dismemberment the result of an accident? ☐ Yes ☐ No

Is this a request for accelerated benefits? ☐ Yes ☐ No

CONTACT PERSON'S INFORMATION

Name (Beneficiary or estate administrator): ____________________________

Street Address: __________________________ Phone: ____________

City: ________________________ State: _______ Zip Code: ______

COVERAGE AMOUNTS

Employee Basic Life: ____________ Coverage Effective Date: __________

Employee Optional Life: ____________ Coverage Effective Date: __________

Spouse Optional Life: ____________ Coverage Effective Date: __________

Child Optional Life: ____________ Coverage Effective Date: __________

AGENCY INFORMATION

Payroll/Personnel Administrator's Name: ____________________________

Phone Number: __________________________ Org ID: ____________

INSTRUCTIONS	*REMARKS*
• When informed of the death or accidental dismemberment of an employee, spouse, or dependent child, complete as many of the above items as possible. • Submit this form to the Employee Benefits Unit within 48 hours of the notice of death. o Fax: 303-866-3879 o Email: state_benefits@state.co.us • For questions call: 303-866-3434 or 1-877-719-3434	