

Claimant's  
Statement

**GLASS, MOLDERS, POTTERY, PLASTICS & ALLIED WORKERS**

PO Box 607, 608 E. Baltimore Pike, Media, PA 19063 - (610) 565-5051

**DEATH BENEFICIARY DEPARTMENT**

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

**CLAIMANT COMPLETE THIS SECTION REGARDING DECEASED**

(Please print)

\_\_\_\_\_  
Deceased Full Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Death

\_\_\_\_\_  
Place of Death

\_\_\_\_\_  
Cause of Death

\_\_\_\_\_  
Attending Physician's Name

\_\_\_\_\_  
Address of Physician

**CLAIMANT COMPLETE THIS SECTION**

(Please print)

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Deceased

\_\_\_\_\_  
Address, Street and Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
City, State and Zip

I am making claim for the payment as: (Check One)

Named Beneficiary  Surviving Lawful Spouse  Surviving Child  Executor or Administrator

Other \_\_\_\_\_

**The following must be attached:**

1. Original Death Certificate.      2. If Claim is for other than named beneficiary, supporting documents must be attached (marriage certificate, letters of administration, birth certificate, etc.)

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

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Claimant

**Do Not Complete This Portion**

Date of Payment \_\_\_\_\_

Amount Paid \$ \_\_\_\_\_

By \_\_\_\_\_

Claim No. \_\_\_\_\_