



## HOW TO FILE A GROUP DEATH CLAIM

### The following items are needed on all Group Death claims:

- 1) An Employer's Notice of Death form completed in full by the Employer
- 2) A copy of the enrollment form furnished by the TPA or the Employer
- 3) A certified copy of the death certificate furnished by the beneficiary
- 4) A Claimant's Notice of Death form completed in full by each beneficiary

### The following items may be needed:

- 1) If the beneficiary dies before the employee, we will also need a certified copy of the beneficiary's death certificate.
- 2) If the beneficiary is the Estate, we will need a certified copy of the court order that appoints someone as the representative of the Estate. The representative of the Estate should complete the Claimant's Notice of Death form and the Estate's tax identification number should be included on the Claimant's Notice of Death form.
- 3) If the beneficiary is a minor, we will need a certified copy of the court order that appoints someone as the guardian of the property of the minor beneficiary. The guardian of the property of the minor beneficiary should complete the Claimant's Notice of Death form and the minor beneficiary's social security number should be included on the Claimant's Notice of Death form.
- 4) If the beneficiary is a Trust, we will need a notarized copy of the Trust. The Trustee should complete the Claimant's Notice of Death form and the Trust's tax identification number should be included on the Claimant's Notice of Death form.
- 5) If the beneficiary has assigned all or any portion of the benefits to a funeral home, please include copies of the assignment and the funeral bill. Please note that a minor beneficiary cannot assign benefits to a funeral home.
- 6) If you are filing for Accidental Death benefits, please include a copy of the police/accident report. Any newspaper clippings would be helpful. A copy of the autopsy report may be necessary depending on the type of accident.

Along with these documents, we shall need verification that the employee has been included in the premium payments for the group through the month of the death.

**To avoid delay in claims processing, please submit ALL required documents together.**

If you have any questions, please call 1-800-447-0460 and ask for the Group Life & Disability Department



## EMPLOYER'S NOTICE OF DEATH

Employer				Address of Employer			
Employee				Address of Employee			
Date of Birth	Social Security No.	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation			
Status (if leave of absence, retired or terminated, please give date) <input type="checkbox"/> Active <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Retired <input type="checkbox"/> Terminated Date:							
Date Employed	Date Employee insured with Employer Basic	If ever terminated & reinstated indicate new effective date: Basic Optional		Employer last contributed to premium for month of:		Employee last contributed to premium for month of:	
Date of Death	If death was due to an accident, was Employee working at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No					Date of Accident	
If death was due to an accident, please state how and where it occurred							
Name of Beneficiary						Relationship to Deceased	
Date last worked	Reason for leaving	Amount of regular earnings for Employee at date of death <input type="checkbox"/> Annual \$ <input type="checkbox"/> Weekly \$				Date of last change of earnings	
Class	Effective Date for current insurance	Amount of Basic Insurance Life Accidental Death			Amount of Optional Insurance Life Accidental Death		
To Be Completed Only If Claim Is Being Made Under Dependent Coverage							
Dependent (Deceased)		Date of Birth	Social Security No.		Relationship to Employee		
Address							
If claim for spouse, was he/she divorced or legally separated from the Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No				If claim for a child, indicate if <input type="checkbox"/> single or <input type="checkbox"/> married			
Was dependent employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes <input type="checkbox"/> Full-time or <input type="checkbox"/> Part-time		If yes, please indicate the name and address of Employer					
If child was a college student, please indicate if <input type="checkbox"/> full-time or <input type="checkbox"/> part-time student and the name and address of the college							
Date Dependent insured with Employer Basic Optional		If ever terminated & reinstated indicate new effective date Basic Optional		Amount Basic Insurance Life Accidental Death		Amount Optional Insurance Life Accidental Death	
Remarks:							
The above information is taken from our records. We certify that the information is accurate and recommend that the claim receive consideration							
Date	Employer					By (Authorized Signature)	



## FRAUD WARNINGS

**Alaska, Delaware, Florida, Idaho, Indiana, New Jersey, Ohio, Oklahoma, Fraud Warning:** “Any person who knowingly, and with the intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony and subject to criminal and civil penalties under the state law. “

**Kentucky and Pennsylvania Fraud Warning:** “Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.”

**New Hampshire Fraud Warning:** “Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.”

**Minnesota Fraud Warning:** “ A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.”

**Arizona, California and Hawaii Fraud Warning:** “ For your protection these states require the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to criminal and civil penalties, fines and confinement in state prison.”

**Arkansas, Louisiana and New Mexico Fraud Warning:** “ Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties, fines and confinement in prison.”

**District of Columbia, Maine, and Virginia Fraud Warning:** “It is a crime to knowingly provide false, incomplete or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits. “

**Colorado Fraud Warning:** “It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.”

**New York Fraud Warning:** “ Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.”



## CLAIMANT'S NOTICE OF DEATH

Employer		Address of Employer	
Employee		Social Security No.	
Full Name of Deceased		Occupation of Deceased, if employed	
Date of Birth	Date of Death	Place of Death	
Cause of Death		Duration of last illness (if death caused by an illness)	
Name and Address of any Attending Physicians			
Full name, address, social security number and date of birth for person making claim (please print and each person should complete a Claimant's Statement)			
Name		Date of Birth	
Address		Phone Number	
Beneficiary's Social Security Number		Estate's Tax Identification Number	
Minor's Social Security Number		Trust's Tax Identification Number	
Other Social Security Number		Other Tax Identification Number	
<p>Certification – Under penalties of perjury, I certify that:</p> <p>a) These statements are complete and true to the best of my knowledge.  I understand that the furnishing of forms by the Company does not constitute an admission that there is any insurance in force, that I am a payee of any proceeds, nor a waiver of any defenses or rights of the Company in any claim which may be asserted.</p> <p>c) I make claim for the proceeds of insurance as _____  (Beneficiary, Spouse, Executor, Etc)</p> <p>d) I hereby waive all provisions of law forbidding or restricting any physician or other person who, at anytime attended or examined the deceased from disclosing in the courts or otherwise, any knowledge, information, or belief which he/she thereby required; I hereby specifically authorize all such persons to freely communicate their knowledge to the Company, if it requires them to do so.</p> <p>e) I further certify that the social security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and</p> <p>f) I am not subject to back up withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to back up withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to back up withholding.  <b>(You must cross out item (f) if you have been notified by the IRS that you are subject to backup withholding because of underreporting interest or dividends on your tax return)</b></p>			
Claimant's Signature		Date	
Witness' Signature		Date	
<p><u>Instructions to the Claimant</u></p> <ol style="list-style-type: none"> <li>1) Please read each question carefully.</li> <li>2) Questions should be answered as fully and as accurately as possible from your own knowledge.</li> <li>3) Please indicate "don't know" if you cannot answer a question.</li> <li>4) Your full name, address, Social Security number and date of birth are very important, please be sure to provide this information.</li> <li>5) You should read and sign the Certification portion of the form. Your signature must be witnessed.</li> <li>6) Along with this completed form, you will need to furnish a certified copy of the death certificate.</li> </ol>			



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