Instructions for Filing a Group Life (or Dependent Life) Claim

How to complete the Group Life Insurance Claim Form

1. Complete Sections A, B, C, D and E of the Group Policyholder Statement portion of the Group Life Insurance Claim Form. In Section C, complete (C1), and (C2) if the claim is for a dependent of an employee.

   For Dependent Life coverage, the employee is usually the beneficiary. See your policy for specific details.

   If the insured was on an approved life disability (waiver of premium) claim, only complete sections A & E of the Group Policyholder Statement and return it along with the Beneficiary Statement(s).

2. Detach the Beneficiary Statement and give it to each beneficiary. Ask each beneficiary to complete and return it to you.

   If there are multiple beneficiaries, each beneficiary should complete this form. It is only necessary for you to submit one Group Policyholder Statement, regardless of the number of Beneficiary Statements completed. If you have difficulty obtaining forms from all beneficiaries, please submit the information you do have. If the beneficiary is an estate, a minor, or not competent to handle financial affairs, the Beneficiary Statement should be completed by the appropriate legal representative (executor, administrator or guardian.)

3. Return **both** the Group Policyholder Statement and the Beneficiary Statement with the required documents noted below to:

   Postal address:
   Assurant Employee Benefits
   Group Life Benefits
   P.O. Box 419876
   Kansas City, Missouri 64141

   Street address:
   Assurant Employee Benefits
   Group Life Benefits
   2323 Grand Boulevard
   Kansas City, Missouri 64108

   FAX/Email
   816.881.8967
   LifeClaims@assurant.com

Documents to submit to Assurant Employee Benefits when filing a life insurance claim

1. Group Policyholder Statement and Beneficiary Statement(s)
2. A certified copy of the death certificate
3. A copy of the employee's enrollment card, if available
4. A copy of all beneficiary changes, if applicable
5. The certificate of insurance (or policy booklet), if available
6. Legal documentation, for the following situations:
   a. **Beneficiary is an estate, a minor, or not competent to handle financial affairs:** attach a certified copy of the court order appointing the legal representative.
   b. **Beneficiary is a trust:** include a letter verifying that the trust is still in effect. If the trust is testamentary, attach a copy of the will and a certified copy of the letters of testamentary.
      If the beneficiary is a trustee or successor trustee under a trust agreement, send a copy of the trust agreement.
   c. **Beneficiary is no longer living:** include a copy of his/her death certificate.
      Note: If the beneficiary died prior to the insured, the benefits would be payable to the contingent beneficiary. If there is no contingent beneficiary named, we would need a ***Surviving Family Claim Statement*** *(form can be downloaded from our web site:* ***www.assurantemployeebenefits.com****) If the named beneficiary died after the insured, the proceeds would normally be payable to the* ***named beneficiary's estate****. We would need a certified copy of the court order appointing the legal representative of the beneficiary's estate.*
7. If an accidental death claim is being filed, attach all available supporting information such as a police report, medical examiner's report or newspaper clippings.
8. If the claim was incurred within the first three months of coverage, payroll records and/or other proof of active work will be required.

If you have any questions, please call our Group Life Benefits Team at 800.451.4531 and a representative will assist you.

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company. In this document, the terms "we," "us," "our," and the like, refer to each as applicable.

Questions & Answers on ProviderFund

Important note regarding payment of benefits: If you are a personal beneficiary whose share of the proceeds plus interest meets our requirements, a ProviderFund account (an interest-bearing checking account) will be opened in your name unless you advise us that you prefer a check be issued. ProviderFund account checks will be supplied upon approval of the claim for benefits allowing you immediate access to your money.

You may immediately use all or a portion of those funds by writing checks against that account. All checks are provided to you free of charge. Your account will earn interest. For a current quote on the interest being paid, call our toll free number.

Q. What is ProviderFund?

A. ProviderFund® is a personal checking account established in your name with the Life insurance policy proceeds, which you claimed and are entitled to as a beneficiary. Since 1990, we have opened and administered ProviderFund® accounts automatically when proceeds from Life insurance claims are $10,000 or more. Payable through State Street Bank in Boston, Massachusetts, the principal and interest in your ProviderFund® account are fully guaranteed by us, an industry leader[1] with a history of financial stability. You have complete control over the funds in this account, and only you can make withdrawals.

Q. What are the benefits?

A. The decisions you are now faced with come at a critical and difficult time. We understand how stressful it can be to have to make important financial decisions so soon after the loss of a loved one. ProviderFund® allows beneficiaries the time they need to decide the best options for their financial futures, while keeping their money safe and accessible, and allowing the unused portions to grow. ProviderFund® gives you immediate access to your money.

Q. How does it work?

A. Your account will be opened as soon as your claim is approved, and your money will begin earning a competitive rate of interest at that time. A Confirmation Certificate, your ProviderFund® checkbook and a supply of checks will be mailed to you shortly after your claim is approved. You may write checks immediately (each with a $250 minimum) or wait as long as you need to decide what to do. At any time, you may write one check to access the entire proceeds in your account. It is entirely your decision. Statements detailing your balance, check activity, and interest earnings will be sent to you each month.

Q. How is interest credited?

A. Interest is earned on the balance in your account from the day it is established to the day it is closed. Interest will be compounded daily and credited to your account on the 20th day of each month. The interest rate is determined by Assurant Employee Benefits, and may be changed at the company's discretion at any time. (Be advised that the interest earned on your account may be taxable.)

[1]Employee Benefit Plan Review, July 2004. Based on number of master contracts in force.

Life Claims Statement

This form may be used for both **employee/member** and **dependent** life insurance claims.

Group Policyholder Statement *(To be completed by Employer/Plan Administrator)*

Section A: Employee/Member Information

Name ______________________________
LAST FIRST MIDDLE INITIAL

Date of birth ____________ Social Security number ____________ State of residence ____________

Address ______________________________
STREET CITY STATE ZIP

Was Deceased on an approved Life Disability (Waiver of Premium) claim? ☐ Yes ☐ No

If "Yes," Policy number ____________ Claim number ____________

If Deceased was on a previously approved life disability (Waiver of Premium) claim, complete Sections A and E only.

Section B: Employer/Association Information

Name of Employer/Association ______________________________

Policy number ____________ Participation number ____________ Account number ____________

Employer address ______________________________
STREET CITY STATE ZIP

Location where employed ______________________________
STREET CITY STATE ZIP

Employer telephone number ____________ Fax number ____________

Web site address ______________________________

Section C: Deceased Information

(C1) ***Please complete for all claims.*** ☐ Full-time ☐ Part-time Hours worked per week ________

Employee/Member's job title ______________________________

Employee pay status: ☐ Hourly ☐ Salaried Salary on last date worked: $__________ per ☐ Hr ☐ Wk ☐ Mo ☐ Yr

Employee date of birth ____________ Date employee employed ____________

Date of death ____________

Effective date of employee's coverage ____________ Last date employee worked ____________

If not actively at work immediately prior to death, what was the reason? *(Check one.)*

☐ Disability ☐ Discharge ☐ Leave of absence ☐ Resigned ☐ Retired ☐ Temporary layoff ☐ Vacation

☐ Other *(Please explain.)* ______________________________

Are Accidental Death benefits being claimed? *(If "Yes," please provide any additional supporting information including police report, Medical Examiner's report and any newspaper articles.)* ☐ Yes ☐ No

Section C2 must be completed for all Dependent Life Insurance Claims.

(C2) Is Deceased a dependent of employee? ☐ Yes ☐ No ***(If "No," please skip to Section D.)***

Name of deceased dependent ______________________________
LAST FIRST MIDDLE INITIAL

Dependent's Social Security number ____________

Relationship to employee: ☐ Spouse ☐ Son ☐ Daughter ☐ Other ____________

Date of birth ____________ Date of death ____________

Effective date of dependent coverage ____________

Dependent's marital status: ☐ Single ☐ Married ☐ Divorced ☐ Legally separated

Dependent's most recent employer ______________________________

If dependent was disabled, please provide disability date ____________

Last date dependent worked ____________

If dependent was 19 or over, was the dependent a full-time student? ☐ Yes ☐ No

If you have any questions, please call our Group Life Benefits Team at 800.451.4531 and a representative will assist you.

Name of employee/member ______________________________
LAST FIRST MIDDLE INITIAL
Date of birth ____________ Social Security number ____________ Policy number ____________

Section D: Insurance Coverage/Claimed Information

Type of insurance and amount (being claimed)

- ☐ Basic Term Life $ ____________
- ☐ Additional Contributory Life (Supplemental) $ ____________
- ☐ Voluntary Life $ ____________
- ☐ Dependent Life (Basic or Voluntary) $ ____________
- ☐ Accidental Death $ ____________
- ☐ Dependent Accidental Death $ ____________
- ☐ Other *(Please specify.)* ____________ $ ____________

Total $ ____________

Was evidence of insurability required on any of the coverage claimed? ☐ Yes ☐ No

Date last premium paid ____________ Was insurance in force at date of death? ☐ Yes ☐ No

Section E: Payment Information

Please provide the following information about the beneficiary(ies) your records reflect. Note that if this is for dependent coverage, the beneficiary is normally the employee. If there are more than three beneficiaries, please attach a sheet with additional names and information.

Is there a beneficiary dispute? ☐ Yes ☐ No

Name of Beneficiary #1 ______________________________

Social Security number ____________ Relationship to Deceased ____________

Name of Beneficiary #2 ______________________________

Social Security number ____________ Relationship to Deceased ____________

Name of Beneficiary #3 ______________________________

Social Security number ____________ Relationship to Deceased ____________

Group Policyholder Statement completed by *(name of representative at employer or administrator that completed this form)*

____
PLEASE PRINT

______________________________ ____________
SIGNATURE (REPRESENTATIVE OF POLICYHOLDER/EMPLOYER) DATE

____
EMAIL ADDRESS

I hereby certify that the information provided on this form is complete and accurate to the best of my knowledge and I have no financial interest in this claim.

Note: Please send all life claim documents to the Kansas City location. Please do not send claim information to our Clinton, Iowa location.

If you have any questions, please call our Group Life Benefits Team at 800.451.4531 and a representative will assist you.

Beneficiary Statement

HOME OFFICE USE ONLY
Claim # ________________ PF opening balance $ ________________

To be completed by each beneficiary *(Please print.)*

Employee/Member's name ______________________________
LAST FIRST MIDDLE INITIAL

Date of birth ________________ Social Security number ________________ Policy number ________________

Section F: Information about you, the beneficiary

Beneficiary's name ______________________________
LAST FIRST MIDDLE INITIAL

Beneficiary's date of birth ________________ Beneficiary's Social Security number ________________

Beneficiary's address ______________________________
STREET CITY STATE ZIP

Daytime phone ________________ Home phone ________________

Email address ______________________________

Beneficiary's relationship to Deceased ______________________________

Is beneficiary a U.S. citizen? ☐ Yes ☐ No *(If "No," an IRS Form W-8BEN will be required.)*

Section G: Taxpayer Identification Number and Certification

IMPORTANT FORM W-9 NOTICE

Under Federal law, every financial institution that pays you interest is required to have you certify: (1) Your Social Security number (or other taxpayer identification number) and (2) whether or not the Internal Revenue Service has notified you that you are subject to a Backup Withholding Order on interest and dividend income and (3) you are a United States person (including a United States alien).

It is very important that we have your Social Security (taxpayer identification) **number and Backup Withholding status certification.** Although everyone must file a certification like the form below (if you do not, the IRS can subject you to a $50 penalty), you are not subject to a Backup Withholding Order, which the IRS uses to collect taxes from people who have not reported their interest or dividend income in the past. If you do not file a certification, the IRS automatically requires all financial institutions to withhold 29% for 2005; 28% after December 31, 2005 of all interest and dividends they credit to your account, and send the money to the IRS as a prepayment of your possible tax liability.

Please complete the form below, sign it, and return it to us with the completed claim form. See "GUIDELINES FOR DETERMINING THE PROPER IDENTIFICATION NUMBER" on the following page. If you do not have a Social Security number (or other taxpayer identification number)**, contact your local Social Security office.**

Life Benefit Center, Substitute Form W-9 **Certification Form of Taxpayer Identification Number**

Please list your Social Security (or other taxpayer identification) number ______________________________

I certify, under penalty of perjury, that 1) the Social Security number of other taxpayer identification number given above is correct. 2) I have not been notified by the Internal Revenue Service that I am subject to a Backup Withholding Order on interest and dividends *(If you have been notified that you are subject to a Backup Withholding Order, please cross out item 2 of this sentence.)*, and 3) I am a United States Person. *(If you are a foreign person, please see above.)*

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Your Signature ______________________________ Date ________________

Please print your name ______________________________

Note: Your signature as signed above will be used to verify your signature for ProviderFund Account Checks.

If you have any questions, please call our Group Life Benefits Team at 800.451.4531 and a representative will assist you.

GUIDELINES FOR DETERMINING THE PROPER IDENTIFICATION NUMBER

Social Security numbers have nine digits separated by two hyphens, i.e., 123-45-6789. Employer identification numbers have nine digits separated by only one hyphen, i.e., 98-7654321. The guidelines below will help determine the number to give on your substitute Form W-9.

1. **For an individual's account**
   Give the Social Security number of the individual.
2. **For an account in the name of a guardian or committee for a designated ward, minor, or incompetent person**
   Give the Social Security number of the ward, minor, or incompetent person.
3. **For an account registered in the name of a valid trust or estate**
   Give the Employer Identification number of legal entity. *(Do not furnish the identification number of the personal representative or trustee unless the legal entity itself is not designated in the account title.)*
4. **For a corporation, religious, charitable, or educational organization**
   Give the Employer Identification number of the organization.

If you do not have a Social Security number or other taxpayer identification number, write "Applied For" in the space for the number, sign and date the form and return to Assurant Employee Benefits. You will have 60 days to obtain a Social Security or other taxpayer identification number and furnish it to us. **(NOTE: Any interest earned by your ProviderFund account during that period will be exempt from Backup Withholding.)**

1. "Applied For" means you have already applied for **or** that you intend to apply for a Social Security or other taxpayer identification number soon.
2. You must complete this form even if you are exempt from Backup Withholding to avoid possible erroneous Backup Withholding.
3. If you are a foreign person, use the appropriate Form W-8.

Section H: Authorization to Release Information / Physician Information

*(**Note**: If insured was on an approved waiver of premium claim this does not need to be completed.)*

1. Occasionally in the processing of a claim it becomes necessary for us to contact an outside source for additional information. The legal representative or next of kin of the insured should sign the authorization below to avoid us having to obtain it at a future date.

   Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, to provide Union Security Insurance Company information concerning advice, care or treatment provided the insured named above or spouse or minor children thereof, any post-mortem examination reports including autopsy, toxicology and investigation. This may include information relating to mental illness, use of drugs or use of alcohol. I authorize any other insurance company to release policy and claim information. I also authorize any employer, group policyholder or benefit plan administrator to provide Union Security Insurance Company with financial or employment related information.

   I understand that the information authorized herein will be used by Union Security Insurance Company to evaluate a claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request. Information obtained will not be released to any person or organization EXCEPT to reinsuring companies, or other person or organization performing business or legal services in connection with the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

   This authorization is valid from the date signed for the duration of the claim.

   Signature ______________________________ Date ______________

2. List the name and address of the employee/dependent's primary physician.

Name	Address	Phone number	Dates treated	Conditions

If you have any questions, please call our Group Life Benefits Team at 800.451.4531 and a representative will assist you.

For your protection, certain state laws require the following to appear on this form.

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive 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.

In addition, any person who commits such a fraudulent act (or facilitates the act):

- may be prosecuted under state law (Alaska residents only).
- may be subject to fines and confinement in prison (Arkansas, California, and New Mexico residents only).
- is subject to penalties that may include imprisonment, fines, denial of insurance, and civil damages (Colorado residents only). Also, 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 of award payable from insurance proceeds shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.
- is guilty of a felony (Delaware, Idaho, Indiana, and Oklahoma residents only).
- is guilty of a felony of the third degree (Florida residents only).
- may be subject to penalties including imprisonment, fines or denial of insurance benefits (Maine residents only).
- may be found guilty of insurance fraud (Maryland residents only).
- is subject to prosecution and punishment for insurance fraud as provided in RSA638:20 (New Hampshire residents only).
- 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 (New York residents only).

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties, include imprisonment, fines, and denial of insurance benefits (Virginia residents only).

Any person who knowingly and with intent to defraud any insurance company or 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 (Pennsylvania residents only).

Pursuant to Section 403(d) and Regulation 95 of the New York Insurance Law, the following statement applies to our accident and health policies only: 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 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.

If you have any questions, please call our Group Life Benefits Team at 800.451.4531 and a representative will assist you.