



Claims Processing Center
P.O. Box 6202
Columbia, SC 29260
1-888-208-1998 • 803-264-6152 (Fax)

GROUP LIFE INSURANCE CLAIM FORM

FRAUD WARNING: (Not Applicable in AZ, FL, MD, OR, VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL only): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

IMPORTANT-READ CAREFULLY

This form is to be fully completed by the claimant/beneficiary and employer and forwarded to the Claims Processing Center at the above address. Along with this completed form, submit a certified death certificate, W-2 and/or payroll records, and enrollment application, if available, with any and all changes of beneficiary forms executed by the insured.

NOTE

Employee must work at least 30 hours per week to be eligible for coverage.

If death has resulted from other than natural causes, a newspaper clipping should be furnished, if available.

If death has resulted from a highway accident, please furnish a copy of the highway accident report.

If death has resulted from homicide, a copy of the police investigation report and coroner's report should be furnished.

If insurance proceeds are payable to the insured's estate, a certificate showing the appointment of the administrator should be furnished.

If insurance proceeds are payable to a minor or mentally incompetent person, a certificate showing the appointment of a *guardian* of the *estate* should be furnished.

If the designated beneficiary is deceased, a certified copy of his or her death certificate should be furnished.

If other requirements are necessary, you will be notified.

EMPLOYER'S CERTIFICATION

To be answered in its entirety for all Group Term claims. If any questions are left unanswered the form will be returned for additional information. Check appropriate box: Group Term Employee Death Group Term Dependent Death

1. Full Name of Employee:

Last First Middle Initial

2. Employee's Address:

Street City State Zip

3. Full Name of Deceased (if other than employee):

Last First Middle Initial

4. Deceased's Address:

Street City State Zip

5. Employee's date of birth:

____/____/____
Month Day Year

6. Sex:

Male
 Female

7. Group Number:

8. Identification Number:

9. Date employee hired full-time:

____/____/____
Month Day Year

10. Effective date of coverage:

____/____/____
Month Day Year

11. Employee's Job Title:

12. Employee's last full work day:

____/____/____
Month Day Year

13. Part-time:

____/____/____
Month Day Year

14. Reason for leaving work:

Resigned Retired Illness Laid off Other (explain)

15. Date and amount of Last Salary Change if life benefits are based on salary:

Date _____
Month Day Year

Hourly Rate \$ _____

Annual Salary \$ _____

16. If employee death, was a claim for disability benefits submitted prior to death? Yes No

If yes, was a claim for: Short Term Disability Long Term Disability Waiver of Premium

17. Was death due to: (check one) Natural Homicide Suicide Accident

18. Was death due to Occupational Accident? Yes No If Yes, enclose copy of Employer's First Report of Injury.

19. Amount of Benefits Claims:

\$ _____ Life, \$ _____ AD&D, \$ _____ Dependent Life

20. Beneficiary:

Last First Middle Initial

Beneficiary's Age:

Beneficiary's Relationship to Deceased:

I CERTIFY THE ABOVE AS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Name of Company Area Code Telephone

Street City State Zip Code

Signature Official Position Date

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