Group Life Insurance Claim Statement

General 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.
AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
AR, LA, MA, MN, NM, RI, TX and WV: 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 fines and confinement in prison.
AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
CA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
CO: 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.
DC: 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 fines and confinement in prison.
DE, ID and IN: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
FL: 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.
KS: 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 may be guilty of insurance fraud as determined by a court of law.
KY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
MD: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME: 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.
NH: 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.

CM Regent Solutions PO Box 812 New Cumberland, PA 17070
T 866.403.7700 Ext. 7334 ● F 866.691.6291

ME: 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.
NH: 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.
NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
OR and VA: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.
PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TN and WA: 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.
VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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

To the Administrator:

A claim for Group Life Insurance benefits should be submitted to CM Regent Solutions as soon as notice is received that an employee/dependent or the employee's beneficiary is eligible for benefits.

Filing of a Claim

1. Along with the Group Employer Statement and Beneficiary Statement, we will also require:
2. Certified copy of the death certificate.
3. Enrollment application and beneficiary changes.
4. If the claim is incurred in the first three months of coverage, payroll records and/or other proof of active work will be required.

If the insured's death is the direct result of an accident, accidental death benefits may be payable if the policy provides accidental death.

If accidental death claim is being filed, attach all available supporting information such as the official investigative report (police, accident, fire, FAA, OSHA), medical examiner's report or newspaper clippings.

The Group Claim should be returned immediately to:

CM Regent Solutions
PO Box 812
New Cumberland, PA 17070

Fax number:

866.691.6291

Life Claims Statement

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

To be completed by the Employer/Plan Administrator

Section A: Employer/Association Information

Name of Employer/Association _____

Policy number **16,555** 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 B: Employee/Member Information *(Please complete for all claims.)*

The deceased is insured as: ☐ Employee ☐ Spouse ☐ Child

Full name of Employee _____
LAST FIRST MIDDLE INITIAL

Social Security number _____ Date of birth _____ Date of death _____

Address _____
STREET CITY STATE ZIP

Hire date _____ Date insurance effective _____ Occupation _____

Annual salary _____ Date of last salary increase _____ Hours worked per week _____

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

Reason for ceasing work: ☐ Disability ☐ Discharge ☐ Leave of Absence ☐ Resigned ☐ Retired
☐ Temporary layoff ☐ Vacation ☐ Other *(Please explain.)* _____

Last date worked _____

Section C: Please complete for all Dependent Life Claims

Full name of deceased dependent _____
LAST FIRST MIDDLE INITIAL

Social Security number _____ Date of birth _____ Date of death _____

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

Full-time student? ☐ Yes ☐ No

Dependent's most recent employer _____

Last date worked _____

If dependent was disabled, please provide disability date _____

Name of employee/member _____
LAST FIRST MIDDLE INITIAL

Date of birth _____

Section D: Insurance Coverage/Claimed Information

Type(s) of insurance and amount(s) **being claimed**

- ☐ Basic Term Life $ _____
- ☐ Additional Contributory Life (Supplemental) $ _____
- ☐ Voluntary Life $ _____
- ☐ Dependent Life (Basic or Voluntary) $ _____
- ☐ Accidental Death $ _____
  - ☐ Automobile Accident $ _____
  - ☐ Higher Education $ _____
- ☐ 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 — A copy of all beneficiary designations must be provided with the claim form.

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. Please list only primary beneficiary(ies).

Is there a beneficiary dispute? ☐ Yes ☐ No

Name of Beneficiary #1 _____

SSN/TIN* _____ Relationship to Deceased _____

Name of Beneficiary #2 _____

SSN/TIN* _____ Relationship to Deceased _____

Name of Beneficiary #3 _____

SSN/TIN* _____ Relationship to Deceased _____

*Social Security Number/Taxpayer Identification Number

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.

Beneficiary Statement

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

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

Employee/Member's name _____
LAST FIRST MIDDLE INITIAL

Date of birth _____ Social Security number _____ Policy number **16,555**

Section F: Information about you, the beneficiary

Beneficiary's name _____
LAST FIRST MIDDLE INITIAL

Beneficiary's date of birth _____

Beneficiary's Social Security/Taxpayer Identification 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," the appropriate IRS Form W-8 will be required.

Are Accidental Death benefits being claimed? ☐ Yes ☐ No

If "Yes," please provide any additional supporting information including police report, Medical Examiner's report and newspaper articles.

*Primary beneficiaries only, unless contingent beneficiaries wish to make a claim.

IMPORTANT TAX INFORMATION

The Federal income tax laws require us to request that you provide us with your correct Social Security Number or Taxpayer Identification Number.

Please read and complete the following information in order to comply with the Federal income tax laws. See "Guidelines for Determining the Proper Taxpayer Identification Number" on the following page.

Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Social Security/Taxpayer Identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person, and
4. I am exempt from FATCA reporting.

NOTE: Certification Instructions – You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

The IRS 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 also be used to verify your signature for ProviderFund® Account Checks.

Name of employee/member _____
LAST FIRST MIDDLE INITIAL

Date of birth _____

GUIDELINES FOR DETERMINING THE PROPER TAXPAYER 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 one hyphen, i.e. 98-7654321. The guidelines below will help determine the number to give us.

1. **For an individual**
   Give the Social Security number of the individual.

2. **For a custodian account of a minor (Uniform Gifts to Minors Act)**
   Give the Social Security number of the minor.

3. **For an account in the name of a guardian for a designated ward, minor, or incompetent person**
   Give the Social Security number of the ward, minor, or incompetent person

4. **For a valid trust or estate**
   Give the Employer Identification number of trust or estate. *(Do not furnish the identification number of the personal representative or trustee.)*

5. **For a corporation, religious, charitable, or education organization**
   Give the Employer Identification number of the corporation or 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 Sun Life Financial. You will have 60 days to obtain a Social Security or other taxpayer identification number and furnish it to us.

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, complete and submit to us the appropriate, IRS Form W-8.

ARE YOU EXEMPT FROM FATCA REPORTING?

You may be subject to FATCA reporting if you are submitting this form for an account maintained outside of the United States by certain foreign financial institutions. If you are submitting the form for an account you hold in the United States, no FATCA reporting is required. If you are a foreign person, complete and submit to us the appropriate IRS Form W-8. For additional information, see General Instructions to IRS Form W-9.

Name of employee/member _____
LAST FIRST MIDDLE INITIAL

Date of birth _____

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 account) will be opened in your name if you so choose. ProviderFund® account drafts (similar to checks) will be supplied upon approval of the claim for benefits allowing you immediate access to your money. For more information, access our ProviderFund® brochure at http://www.assurantemployeebenefits.com/816/aebcom/forms/claims/k2796.pdf.

The Benefits of Choosing a ProviderFund® Account

Options: You are allowed the time you need to make important financial decisions and to decide the best options for your financial future during this critical and difficult period.

Secure: All amounts are fully protected and guaranteed by Union Security Insurance Company a company whose financial strength is rated A-(Excellent) by AM Best. These accounts are not insured by the Federal Deposit Insurance Corporation (FDIC).

Free: You will receive unlimited free drafts and monthly statements as long as your account is open.

Accessible: You may write drafts for any amount over $250 and up to your full balance at any time.

Interest: Your account earns interest the day the account opens. Interest is compounded daily and credited to your account on the 20th day of each month.

Service: You can call 800.451.4531, ext. 2802 during regular hours to speak with an Account Representative for assistance with your account. In addition, you can call a 24-hour toll-free line at 888.227.1308 for quick updates on your account.

Please choose your method of payment:

☐ I choose to participate in the ProviderFund® Account option. We will send you a supplemental contract to complete before we can set up account.

☐ I prefer to receive a lump sum check.

Section G: 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 _____

Name of employee/member _____
LAST FIRST MIDDLE INITIAL

Date of birth _____

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

Name	Address	Phone number	Dates treated	Conditions

BENEFICIARY INSTRUCTIONS

If the insured did not name a beneficiary or if a named beneficiary has predeceased the insured:

- Forward a certified copy of the death certificate for any named beneficiary who predeceased the insured.
- Payment of the life insurance benefits will be paid in the order as specified in the policy provisions of the contract.
- The next of kin must complete a Surviving Family Statement (Form KC2181A).

If the beneficiary is the estate:

- Payment of the life insurance benefits will be made to the executor/administrator of the estate. The executor/administrator is appointed by the probate court and is responsible for managing the insured's estate. Please note that a person named as the executor/administrator in the insured's last will and testament must be appointed by the court before payment can be made.
- The executor/administrator of the estate should complete the Claimant's Statement and provide a certified copy of the Letters of Testamentary or Letters of Administration issued by the probate court. The estate Tax Identification number, (not Social Security number) is required on the Claimant's Statement.

If the beneficiary is a minor:

- In order to receive payment of life insurance proceeds, a beneficiary must be of the age of majority, as determined by the state where the beneficiary resides. In most states, the age of majority is considered to be 18 years of age.
- If the beneficiary is under 18 years of age, then the parent or guardian of the minor beneficiary should complete and sign the Claimant's Statement. The proceeds will be deposited into a blocked ProviderFund® account until:
  - The minor beneficiary reaches the age of majority; alternatively,
  - Payment will be made to a court appointed guardian of the minor's estate. A guardian is appointed by the court and is responsible for managing the minor's estate. A copy of the Letters of Guardianship of the minor's estate must be forwarded to our office.

If the beneficiary is a trust:

- When a trust or trust agreement is designated as the beneficiary, a copy of the following pages of the trust must be provided: **Face page of Trust, Trustee or Successor Trustee designation, Signature Page of Trust**.

If the insured's death is a direct result of an accident, accidental death benefits may be payable if the policy provides accidental death.

- If accidental death claim is being filed, attach all available supporting information such as the official investigative report (police, accident, fire, FAA, OSHA), medical examiner's report or newspaper clippings.

HIPAA Authorization for Release of Protected Health Information

Insured/Member name _____ SS no. _____

Address _____ City _____ State _____ Zip code _____

Individual who is the Subject of Protected Health Information _____

Policy no. **16,555** Participation no. _____ Account no. _____ Certificate no. _____

Persons/categories of persons providing the information: Entities possessing the information identified below, including physicians, any provider of medical services, pharmacy, pharmacy benefits manager, or any pharmacy-related services entity, insurance company, Social Security Administration, governmental agency, vocational provider or employer having medical information with respect to any physical or mental condition of the Individual referenced above.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance Company of New York ("Companies").

I hereby authorize the use or disclosure of protected health information regarding the Individual referenced above, as described below:

Description of information to be disclosed: Records concerning medical advice, care or treatment. This may also include, but is not limited to: information relating to use of drugs or use of alcohol; post-mortem examination reporting, including autopsy, toxicology and investigation reports; accident reports made by ambulance, law enforcement and paramedics; other insurance carriers or a prior life insurance carrier or life insurance policy and related claim information; and financial or employment-related information.

The sole purpose of this disclosure is for the adjudication of a claim for life insurance benefits under the Policy referenced above.

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it any time by writing Sun Life Financial, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only – we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.
- The authorization is effective from the date signed below until a final adjudication of the claim for life insurance benefits is reached or 24 months from date of signature, whichever comes first.

_____ _____

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE

Printed name of personal representative _____

Relationship to insured/member _____

(e.g. LEGAL GUARDIAN, EXECUTOR, ADMINISTRATOR, OR NEXT-OF-KIN)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Please make a copy of the signed Authorization for your records. Then please mail or fax the completed and signed Authorization for processing to the appropriate address below, attention Life Claims:

Insurance products are underwritten by Union Security Insurance Company (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (Wellesley Hills, MA).

CM Regent Solutions PO Box 812 New Cumberland, PA 17070
T 866.403.7700 Ext. 7334 ● F 866.691.6291