
Surviving Family Claim Statement



ASSURANT

Employee
Benefits

For your protection, the following disclosures are required by state law and are based on the state where you live:.

If you live in the states of Alaska or Oregon, the following statement applies to you:

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.

If you live in the states of Arizona or New Jersey, the following statement applies to you:

A person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

If you live in the states of Arkansas, Louisiana, Maryland, or Rhode Island the following statement applies to you:

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.

If you live in the state of California, the following statement applies to you:

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.

If you live in Colorado, the following statement applies to you:

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

If you live in Delaware, Florida, Idaho, Indiana or Oklahoma, the following statement applies to you: WARNING:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony. In Florida, it is a felony of the third degree.

If you live in the District of Columbia, Tennessee or Virginia the following statement applies to you:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

If you live in New Hampshire, the following statement applies to you:

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.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

Assurant Employee Benefits is the brand name for insurance products underwritten by Union Security Insurance Company.

Please return this form to:

Assurant Employee Benefits PO Box 973050 El Paso TX 79997-3050
• T 800.451.4531 • F 816.881.8967 • Life Claims@assurant.com www.assurantemployeebenefits.com

If you live in New York the following statement applies to you:

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 live in Minnesota, the following statement applies to you:

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

If you live in Texas, the following statement applies to you:

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.

If you live in a state other than mentioned above, the following statement applies to you:

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.

Instructions

- If the insured did not name a beneficiary or if a named beneficiary has predeceased the insured, please
 - A. Forward a certified copy of the death certificate for any named beneficiary who predeceased the insured.
 - B. Have this form completed by the first of the following surviving family members: 1) lawful spouse (including, where applicable, civil union partner and domestic partner) 2) son or daughter; 3) father or mother.
If there are no surviving family members, the statement must then be completed by the executor or administrator of the estate of the insured.*
 - C. Forward a copy of the insured's obituary/death notice.
- If a Survivor Income Benefit is being claimed, please
 - A. Have all questions, except number 8, completed in full.
 - B. Furnish proof of age (*birth certificate, if available*) of spouse and all children for whom benefits are being claimed.

1. Full name of insured	2. Social Security no.	3. Date of death
4. Name of policyholder		5. Policy no.

6. Did the insured leave a lawful spouse (including, where applicable, civil union partner and domestic partner) living at the time of death? Yes No

Full name of spouse (*if living*) Social Security no. Full address Date of birth

Has the spouse remarried since the insured's death? Yes No If "Yes," provide the date of marriage

7. Were any children of the insured (*including those by any marriage or legal adoption*) living at the time of death?
 Yes No

Full name of sons and daughters (<i>if living</i>)	Social Security no.	Full address	Date of birth	Marital status

8. Were the parents of the insured living at the time of death? Mother: Yes No
Father: Yes No

Full names of mother and father (*if living*) Social Security no. Full address Date of birth

9. Signature _____ Date _____

Witness _____

*Executors or administrators completing this form should attach a certified copy of the court order evidencing their appointment.