Life Claim Statement
Employee/Claimant

ASSURANT
Employee
Benefits

☞ **If you live in the state of Arizona, the following statement applies to you:**
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.

☞ **If you live in the states of Arkansas, Louisiana or Texas, 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:**
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.

☞ **If you live in the state of 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 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.

☞ **If you live in the District of Columbia, 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 the state of Florida, the following statement applies to you:**
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 of the third degree.

☞ **If you live in the state of New Jersey, the following statement applies to you:**
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

☞ **If you live in the state of New York, the following statement applies to you:**
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 live in the state of Oregon, the following statement applies to you:**
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 be guilty of insurance fraud.

☞ **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.

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 PO Box 419876 Kansas City Missouri 64141-6876
T 800.451.4531 F 816.881.8967
www.assurantemployeebenefits.com

GROUP LIFE CLAIM INSTRUCTIONS

To the Administrator:

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

Filing of Claim

Along with the Group Employer Statement and Employee/Claimant Statement, we will also require:

1. Certified copy of the death certificate.
2. Application and beneficiary changes.
3. Verification of eligibility, actively at work status and current salary.
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 Group Policy contains accidental death benefits.
- The cause of death is "accidental" as defined under the group policy.
- The policy exclusions do not apply. (*Please refer to the group policy.)*

The official police or fire department report of the accident must be furnished to determine if accidental benefits are payable. If a toxicology test is administered, the official results of the test must be provided. We may need other information or reports to determine if the death is accidental under the policy.

If the insured died outside of the United States or the beneficiary is living in a foreign country:

- call 800.451.4531 to speak to a claims representative.

The Group Claim should be returned immediately to:

Assurant Employee Benefits
Life Benefit Center
PO Box 419876
Kansas City, MO 64141-6876

Street address:

Assurant Employee Benefits
2323 Grand Boulevard
Kansas City, MO 64108

Fax number:

816.881.8967

The Group Life Claim Packet consist of ____ sections *(not all sections will apply to every claim)*.

Type of Group Life Claim	**Provide these sections**
Employee Life	KC2176G KC2176H
Accidental Death	KC2176G KC2176H
Dependent Life	KC2176G KC2176A
Accidental Dismemberment	KC1714A

Failure to provide complete information may delay processing of the claim. If you have questions regarding the completion of these sections, call your claims representative at 800.451.4531.

Claimant Statement

This form is to be completed by each person(s) to whom the policy is legally payable as beneficiary. When there is more than one beneficiary, separate forms must be completed by each beneficiary. A certified copy of the death certificate must be returned to the **employer** along with this form.

Failure to provide the following information may delay processing of this claim. If you have questions regarding the completion of these sections call your claims representative at 800.451.4531.

LIST THE NAME AND ADDRESS OF THE EMPLOYEE'S PRIMARY CARE PHYSICIAN.

Name	Address	Dates	Condition(s)

Claimant Information

1. Full name of claimant *(Please print.)*			2. Date of birth
3. Legal residence of beneficiary *(street, city, town, state, zip code)*			4. E-mail address
5. Telephone no.	6. Relationship to deceased	7. Beneficiary's Social Security no./Tax ID no.	
8. Beneficiary signature			9. Date

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 800.451.4531 extension 2802.

For more information please review the Beneficiary Instructions on page 4.

Waiver of Premiums (For Home Office Use Only) Amount of Insurance $_____

Insured _____ CDB Claim no. _____

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 & 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 as guardian of the minor. The minor's Social Security number and date of birth should be indicated on 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 the direct result of an accident, accidental death benefits may be payable:

- The Group Policy contains accidental death benefits or insured chose to elect accidental death benefits (voluntary).
- The cause of death is "accidental" as defined under the group policy.
- The policy exclusions do not apply. *(Please refer to the group policy.)*

The official police or fire department report of the accident must be furnished to determine if accidental benefits are payable. If a toxicology test is administered, the official results of the test must be provided. We may need other information or reports to determine if the death is accidental under the policy.

AUTHORIZATION TO RELEASE INFORMATION

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.

Date _____ Signature _____

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 to you that we have your Social Security number *(or other 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 unless you have been so notified by the IRS. (A relatively small percentage of people are now 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 at least 30% (29% after December 31, 2003; 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 **immediately** complete the form below, sign it, and return it to us with the completed claim form. If you do not have a Social Security number *(or other taxpayer identification number)*, it is easy to apply for one at a local Social Security office.

Life Benefit Center
Substitute Form W-9

Certification Form of
Taxpayer Identification Number

Please list your Social Security number _____ *(or other taxpayer identification number—see page 6 for help).*

I certify, under penalty of perjury, that 1) the Social Security number or 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 so notified by the IRS, please cross out item 2 of this sentence.)* **and 3) I am a United States Person.** *(If you are a foreign person, please submit the appropriate Form W-8.)*

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 _____

Please return this form immediately to: Assurant Employee Benefits
Life Benefit Center
PO Box 419876
Kansas City, MO 64141-6876

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

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.

Please return this form immediately to:

Assurant Employee Benefits
Life Benefit Center
PO Box 419876
Kansas City, MO 64141-6876