Companion Life

GROUP LIFE INSURANCE CLAIM FORM

P.O. Box 1535
Dubuque, IA 52004-1535
877-676-5789

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 Companion Life at the above address. Along with this completed form, submit a certified death certificate, W-2 and/or payroll records three months prior to last day worked, and enrollment application, if available, with any and all changes of beneficiary forms executed by the insured. If self-administered, a current census is required 12 months prior to the last day worked or date of death. If self-billed group, please provide a census one year prior to date of death. If a census is not provided, claim will be delayed or possibly denied.

NOTE

Only active, full-time employees are eligible for group life insurance benefits. Part-time or retired employees are not eligible for coverage unless a special provision has been provided for in your group life insurance policy.

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 and coroner's report should be furnished with toxicology reports.
If death has resulted from an accident, please furnish a copy of accident report and coroner's report with toxicology results should be furnished.
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/Vol. Life $_____ AD&D/Vol. AD&D
    $_____ Dep. Life/Vol. Dep. Life $_____ Supplemental 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 _____
Email Address _____

Continued on the back

CLAIMANT'S/BENEFICIARY'S CERTIFICATION

21. Name of Deceased: _____ (Last) _____ (First) _____ (Middle Initial)

22. Age:

23. Sex: ☐ Male ☐ Female

24. Date Deceased last worked:
Full-Time ___ ___ ___ (Month Day Year) Part-time ___ ___ ___ (Month Day Year)

25. Reason for cessation of full-time work:

26. List all Physicians who attended or prescribed to deceased in the last three years:

Physician's Name	Physician's Address
Dates of Attendance	Disease/Condition

Physician's Name	Physician's Address
Dates of Attendance	Disease/Condition

27. If hospitalized, in last three years, please list the following:

Hospital Name	Hospital Address	Date Hospitalized From	To
Hospital Name	Hospital Address	From	To

28. Relationship to Deceased:

29. Your Age:

30. Your Social Security No. ___ - ___ - ___

*** COMPLETE QUESTIONS 31 THROUGH 34 ONLY IF THIS IS A DEPENDENT DEATH CLAIM**

31. How long did the Deceased live in your home? _____

32. If death of spouse, indicate if ☐ legally separated or ☐ divorced, and on what date _____

33. Was your spouse/child working? ☐ Yes ☐ No
If Yes, indicate ☐ Full-time ☐ Part-time. Place of employment _____

34. If death of child, was he or she a full-time student in an accredited school or college? ☐ Yes ☐ No
If Yes, for what period(s)? _____

MEDICAL AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical facility, insurance company, governmental agency, Medicare Part A and Part B carrier, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of the above named insured's health, including information relating to mental illness, use of drugs or alcohol, to give Companion Life Insurance Company or their reinsurers any such information. A photostatic copy of this authorization shall be considered as effective and valid as the original.

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

_____ (Claimant's/Beneficiary's Signature) _____ (Date) ( ) _____ (Area Code Telephone Number)

_____ (Street) _____ (City) _____ (State) _____ (Zip Code)

OPTIONAL MODES OF SETTLEMENT

☐ Option A: Interest only, with right of withdrawal interest payable: Annually ☐ Semiannually ☐ Quarterly ☐ Monthly ☐
☐ Option B: Fixed installments in equal _____ installments of $ _____
☐ Option C: Single Benefit amount

UNDER PENALTIES OF PERJURY: I certify (1) that the number shown on this form is my correct taxpayer identification number, and (2) that I am not subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding. (If subject to backup withholding, please cross out #2.)

AUTHORIZATION TO RELEASE INFORMATION: I hereby certify that the above statements are true and complete to the best of my knowledge. I author-ize any provider of healthcare, insurance company, physician, hospital or government agency to disclose and furnish to Companion Life Insurance Company any information or records relating to this claim. Any information provided is to be used only to determine eligibility for benefit under this insurance policy.

Claimant's Signature: _____ Date: _____ Relationship to Deceased: _____