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## Dependent's Life Claim Statement

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- ☞ 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 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.***

# Dependent's Life Claim Statement



## Part 1—To be completed by Insured

1. Full name of insured ( <i>Please print.</i> ) _____		2. Name of deceased dependent _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. Dependent's legal residence ( <i>street, city or town, state, zip code</i> ) _____			
4. Dependent's date of birth _____	5. Relationship to insured _____	6. Deceased dependent was: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced _____ <input type="checkbox"/> Legally separated _____ <span style="margin-left: 100px;">DATE</span> <span style="margin-left: 100px;">DATE</span>	
7. If deceased dependent was employed, state name and address of employer. _____			
8. If dependent was a child 18 or older, was the child a full-time student at the time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of school _____ Dates attended _____			
9. Date of death _____	10. Cause of death _____	11. Was dependent hospital confined at the time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide the inclusive dates of confinement _____ Hospital name/address _____	
12. The above statements are true and complete to the best of my knowledge. Signature of insured _____ Date _____ Social Security no. _____ Address _____ <span style="margin-left: 100px;">STREET</span> <span style="margin-left: 100px;">CITY OR TOWN</span> <span style="margin-left: 100px;">STATE</span> <span style="margin-left: 100px;">ZIP CODE</span>			

## Part 2—To be completed by Employer

1. Full name of insured ( <i>Please print.</i> ) _____		2. Insured's certificate no. _____	3. Insured's date of birth _____
4. Insured's date employed _____		5. Insured's occupation, title or position _____	
6. Is insured still employed on an active, full-time basis? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please provide date last worked and reason for not working after this date. _____			
7. Effective date of insurance: A. on employee _____ B. on dependent _____		8. Amount of dependent's insurance being claimed ( <i>If over \$10,000, see reverse side.</i> ) _____	
9A. Insured's basic salary rate as of the policy determination date ( <i>Please refer to your Group Policy Schedule.</i> ) _____			9B. Insured's life insurance amount _____
10. Was insurance in force at date of dependent's death? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," give date and reason for termination. _____			
11. Are you satisfied that the relationship and other statements relating to the deceased dependent have been correctly stated by the employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please explain. _____			
12. Have you any additional information relating to this claim? Please explain. _____			

13. We hereby certify that the above facts are true to the best of our knowledge.

**Along with the completed Dependent's Life Claim Statement, please forward the following:**

**A copy of the insured's application (*if maintained by the policyholder.*)**

**A certified copy of the Death Certificate**

**Return to: Fortis Benefits Insurance Company**  
Life Benefit Center  
PO Box 419876  
Kansas City, MO 64141-6876  
Telephone (800) 451-4531  
Facsimile (816) 881-8967

Policy no. \_\_\_\_\_ Participation no. \_\_\_\_\_  
Name of employer \_\_\_\_\_  
Branch or affiliate \_\_\_\_\_  
Authorized signature \_\_\_\_\_  
Date \_\_\_\_\_

**Part 3—To be completed by Beneficiary**

**Important Information for Beneficiaries**

Failure to provide the following information in Section A or B may delay processing of this claim. If you have questions regarding the completion of these sections call your claims representative at **1-800-451-4531**.

**A. LIST THE NAMES AND ADDRESSES of all doctors and hospitals who treated the deceased insured within the last five years. (Use a separate sheet if necessary.)**

Name	Address	Dates	Condition(s)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**B. 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 Fortis Benefits 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 Fortis Benefits Insurance Company with financial or employment related information.

I understand that the information authorized herein will be used by Fortis Benefits 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 Fortis Benefits 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 \_\_\_\_\_

**C. FILING OF CLAIM**

Along with the Life Claim Statement, we will also require:

1. Certified copy of the death certificate.
2. Application and beneficiary changes *(if maintained by the policyholder)*.
3. If the beneficiary is a minor, we will require certified letter of guardianship for the minor's estate.
4. If the beneficiary is the Estate, we will require certified letters of testamentary appointing the executor/administrator of the estate.
5. If the claim is incurred in the first three months of coverage, payroll records or other proof of active work will be required.

**D. PAYMENTS OF BENEFITS**

If you are a personal beneficiary whose share of the proceeds plus interest exceeds the required minimum of \$10,000, a ProviderFund account will be automatically opened in your name unless you advise us that you prefer one of the other settlement options. ProviderFund account checks will be supplied upon approval of the claim for benefits allowing you immediate access to your money.

In addition to ProviderFund accounts, Fortis Benefits Insurance Company also offers settlement options. For a complete discussion of these options, call your claims representative at **1(800) 451-4531**.

**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 dividends.

**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 31% 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.

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**Substitute Form W-9** **Certification Form of  
Taxpayer Identification Number**

Beneficiary's Social Security number \_\_\_\_\_

**I certify, under penalty of perjury, that 1) the Social Security number or other taxpayer identification number given above is correct and 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 notified, please cross out the portion of the sentence beginning with "2.")

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

\_\_\_\_\_  
BENEFICIARY'S SIGNATURE DATE

\_\_\_\_\_  
BENEFICIARY'S NAME (PLEASE PRINT.)

Please return this form to: **Fortis Benefits Insurance Company**  
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.