# Colonial Life Universal Proof of Death Form

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| FAX this direction | FAX this form: **1-800-880-9325**<br>Or mail: P.O. Box 100194, Columbia, SC 29202 | From:<br>Number of pages: |

**Life Policy(s) only**

**Life benefit proceeds due will be paid in a lump sum.**

The policy may contain other payment options. Please review the policy and notify us if you would like to request an alternative payment option.

## Instructions

### STEP I

In order to assist us in processing the claim, the Beneficiary's Statement in Section 1 should be completed by the person(s) to whom the insurance is payable. Where there is more than one beneficiary, all may sign one statement, or a separate form will be furnished for each if desired. Answering all questions will help avoid processing delays. If any questions are left unanswered, the form may be returned for additional information.

When the policy is payable to the estate of the deceased, the statement should be completed by the executor of the estate or administrator, and a certificate showing the appointment of the administrator or executor of the estate should be furnished. If no one has been appointed, contact your attorney or the courthouse in the county where the insured lived to determine the required process.

When the policy is payable to a minor, intellectually disabled, or incapacitated person, the statement should be completed by a guardian, and a certificate showing the appointment of the guardian should be furnished. Please consult your attorney or the courthouse in the county where the minor, intellectually disabled, or incapacitated person resides to determine what process is required.

When the beneficiary named in the policy is deceased, a certified copy of the death certificate of any deceased beneficiary should be furnished. The Beneficiary's Statement must be completed by the person entitled to the proceeds according to the policy terms.

Review the Community Property statement and complete release section as needed.

### STEP II

**For life coverage that has been in force less than two years**

The **PHYSICIAN'S STATEMENT** in Section 3 should be completed by the physician attending the deceased during the last illness or by the deceased's personal physician.

**For a loss due to an accident**

If unable to obtain the Attending Physician Statement, submit a copy of all itemized medical bills or medical records related to the accident. If the death occurred instantly after the injury and no medical treatment was given, a physician's statement is not required.

### STEP III

**A CERTIFIED DEATH CERTIFICATE must be furnished or a copy of the death certificate.**

Returning the original policy to us, if available, will help expedite the claim process. If you do not have the original, please indicate on the claim form. We do not need the policy returned on a dependent unless the policy is in the dependent's name.

Forwarding any electronic or paper media coverage of the death or burial could help expedite the claim process.

By furnishing forms and investigating the claim, the Company does not admit there is any insurance in force and does not waive any of its rights or defenses.

# Claim Fraud Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming require the following statement to appear on this claim form.

**Fraud Warning:** Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

**California:** Any person who knowingly presents 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.

**Colorado:** 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.

**District of Columbia:** 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.

**Florida:** 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.

**Kentucky:** 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.

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

**New Hampshire:** 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.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York:** 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 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.

**Pennsylvania:** 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.

**Puerto Rico:** 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 with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are 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.

## Section 1 Beneficiary's Statement

| | | | |
|---|---|---|---|
| **Complete for all Death Claims.** | | | |
| **Deceased name in full:** | | | |
| List other names by which the insured may have been known, such as maiden name, hyphenated name, nickname, derivative form of first and/or middle name or an alias. | | | |
| Deceased address: | City: | State: | ZIP: |
| SSN: | DOB: _____ / _____ / _____ | **Note:** If date of birth does not agree with the birth date on policy, submit proof of correct age. | |
| Driver's license number: | Issue State: | Date of Death: _____ / _____ / _____ | |
| Place of death: | Cause of death: | | |

**List policies under which the claim is being made:**

| Policy number | Amount of insurance | Please return the policy if available. If the policy is not available, explain below. |
|---|---|---|
| | | |
| | | |

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|---|---|---|---|
| Beneficiary's SSN: | Beneficiary's DOB: _____ / _____ / _____ | Relationship to deceased: | |
| Beneficiary's address: | | | |
| City: | State: | ZIP: | Telephone: |

| | | | |
|---|---|---|---|
| Witness name: | Witness signature: | | |
| Witness address: | City: | State: | ZIP: |
| Special Notice for Residents of a Community Property State: A spouse may have an interest in life insurance proceeds. If you are not the spouse and live in a community property state, the spouse will need to complete below. | | | |
| **Community Property Release** *(Required only in states with community property laws: AK, AZ, CA, ID, LA, NV, NM, PR, TX, WA and WI.)* | | | |
| By signing below, you the spouse agree to the changes indicated and: | ☐ Give up all your rights to this policy according to the community property laws in your state.<br>☐ Do not give up your rights to this policy. | | |
| Signature of Spouse | | | Date ____ /____ /_____ |
| Street Address | | Daytime Tel. (  ) | |
| City | | State | Zip |
| Signature of Witness | | | Date ____ /____ /_____ |
| Check here when no signature is required, because: ☐ Spouse is deceased | | | |

# Certification

Policy owner's name: _____ SSN: _____

I have checked the answers on this claim form, and they are correct. I certify under penalty of perjury that my correct Social Security number is shown on this form. I acknowledge that I received the Claim Fraud Statements on page two of this form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form.

**Fraud Warning:** For your protection, Arizona law requires the following to appear on this claim form:
Any person who knowingly and with the intent to injure, defraud or deceive an insurance company 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.

**Fraud Warning:** For your protection, New York law requires the following to appear on this claim form:
Any person who knowingly and with the 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 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.

**Fraud Notice:** Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalities. This includes the Physician Statement portion of the claim form.

| Beneficiary's name | Beneficiary's signature | Date (MM/DD/YYYY) |
|---|---|---|
| _____ | _____ | _____ |

## Section 2 Complete if the life policy has been in force less than two years.

| | | |
|---|---|---|
| **Did deceased visit a physician in the last five years?** ☐ YES ☐ NO **If yes, please give the following information on all physicians seen in the past 5 years.** | | |
| Physician: | Address: | Telephone: |
| Dates of attendance: _____/_____/_____ _____/_____/_____ _____/_____/_____ | | Diagnosis or illness: |
| Physician: | Address: | Telephone: |
| Dates of attendance: _____/_____/_____ _____/_____/_____ _____/_____/_____ | | Diagnosis or illness: |
| **Did deceased receive hospital inpatient or outpatient treatment in the past five years?** ☐ YES ☐ NO If yes, provide hospital information for the past 5 years. | | |
| Hospital: | Address: | Telephone: |
| Dates treated/confined: _____/_____/_____ _____/_____/_____ _____/_____/_____ | | Diagnosis or illness: |
| Hospital: | Address: | Telephone: |
| Dates treated/confined: _____/_____/_____ _____/_____/_____ _____/_____/_____ | | Diagnosis or illness: |

## Section 3 This statement is to be furnished without expense to the company. Complete if the life policy has been in force less than two years.

### Physician Statement (must be completed by physician)

| | | | |
|---|---|---|---|
| Deceased name in full: | | Age at death: | |
| Residence at death: | City: | State: | ZIP: |
| How long have you known the deceased? | | | |
| Date first consulted for the condition which directly or indirectly caused death? | | | |
| How long did the disease or impairment exist? | Date of onset of first symptom/sign according to the clinical history: _____/_____/_____ | | |
| Other chronic diseases or impairments: | | | |

**Provide information for which you treated or advised deceased prior to last illness.**

| | | | |
|---|---|---|---|
| Disease/condition: | Date: _____/_____/_____ | Duration: | Result: |
| Disease/condition: | Date: _____/_____/_____ | Duration: | Result: |
| Disease/condition: | Date: _____/_____/_____ | Duration: | Result: |

**Provide information for the hospitals where the deceased received inpatient or outpatient treatment in the past five years.**

| | | |
|---|---|---|
| Hospital: | Address: | Telephone: |
| Dates treated/confined: _____/_____/_____ _____/_____/_____ _____/_____/_____ | | Diagnosis or illness: |
| Hospital: | Address: | Telephone: |
| Dates treated/confined: _____/_____/_____ _____/_____/_____ _____/_____/_____ | | Diagnosis or illness: |
| Hospital: | Address: | Telephone: |
| Dates treated/confined: _____/_____/_____ _____/_____/_____ _____/_____/_____ | | Diagnosis or illness: |

**Provide information of physicians/practitioners who attended deceased in the past five years.**

| | | |
|---|---|---|
| Name: | Address: | Telephone: |
| Dates treated: _____/_____/_____ _____/_____/_____ _____/_____/_____ | | Diagnosis or illness: |
| Name: | Address: | Telephone: |
| Dates treated: _____/_____/_____ _____/_____/_____ _____/_____/_____ | | Diagnosis or illness: |
| Name: | Address: | Telephone: |
| Dates treated: _____/_____/_____ _____/_____/_____ _____/_____/_____ | | Diagnosis or illness: |

**Fraud notice:** Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes physician portions of the claim form.

| Physician's name | Physician's signature | Date |
|---|---|---|
| | | |

| | | | |
|---|---|---|---|
| Address: | City: | State: | ZIP: |
| Tax ID: | Telephone: | Fax: | |

## Section 4 Complete this section if loss due to an accident.

| | | | |
|---|---|---|---|
| Place of death: | Cause of death: | | |
| Did injury arise from employment? ☐ YES ☐ NO | Employer name: | Telephone: | |
| Last day worked: _____ / _____ / _____ | Address: | State: | ZIP: |
| How did the injury occur? | Where did the injury occur? | | |
| Date of injury: _____ / _____ / _____ Time: _____ ☐ AM ☐ PM | Occupation at death: | | |
| Had deceased used drugs or medication within ten days prior to date of injury? ☐ YES ☐ NO | If yes, list all drugs and medications: | | |

## Section 5 This statement is to be furnished without expense to the company. Complete this section if loss due to an accident.

**Physician Statement** (must be completed by physician)
**If unable to obtain a physician statement, submit a copy of all itemized bills and/or medical records related to the accident.**

| | | | |
|---|---|---|---|
| Deceased name in full: | | Age at death: | |
| Immediate cause of death: | | | |
| State the precise nature and extent of the injury: (list fractures treated, indicate if open/closed reduction) | | | |
| Date of injury: _____ / _____ /_____ | Dates of total disability: From: _____ / _____ /_____ Through: _____ / _____ /_____ | | |
| Date of deceased's first visit: _____ / _____ /_____ | Date of deceased's last visit: _____ / _____ /_____ | | |
| Dates of hospital confinement: Admitted: _____ / _____ /_____ ☐ AM ☐ PM Released: _____ / _____ /_____ ☐ AM ☐ PM | | | |
| Hospital: | Telephone: | | |
| Address: | City: | State: | ZIP: |
| Was the physical condition of deceased at the date of injury such that the injury would have produced the death independent of all other causes? ☐ YES ☐ NO | | | |
| Have you previously treated deceased? ☐ YES ☐ NO | If yes, date of treatment: _____ / _____ /_____ Description of treatment: | | |

**Provide information of physicians/practitioners who attended deceased after the last injury described above:**

| | | |
|---|---|---|
| Name: | Address: | Telephone: |
| Dates treated: _____/_____ /_____ _____/_____ /_____ _____/_____ /_____ | Diagnosis or illness: | |
| Name: | Address: | Telephone: |
| Dates treated: _____/_____ /_____ _____/_____ /_____ _____/_____ /_____ | Diagnosis or illness: | |

**Fraud notice:** Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes physician portions of the claim form.

| Print physician's name | Physician's signature | Date |
|---|---|---|

| | | | |
|---|---|---|---|
| Address: | City: | State: | ZIP: |
| Tax ID: | Telephone: | Fax: | |

# Authorization for Colonial Life & Accident Insurance Company

Sign and return this authorization to Claims Department at the address listed above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company and its duly authorized representatives (Colonial Life).

Health information may be disclosed by any medical or medically related provider or institution, rehabilitation professionals, vocational evaluators, health plan or health care clearinghouse that has any records or knowledge about me, including prescription drug database or pharmacy benefit manager, ambulance or other medical transport service, any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Non-health information may be disclosed by any entity, person or organization that has any records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution, consumer reporting agencies including credit bureaus, professional licensing bodies, attorneys or governmental entities.

Health information includes my entire medical record, prescription drug history and insurance claim history, including HIV, AIDS or other disorders of the immune system, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, use of drugs or alcohol, mental or physical history, condition, advice or treatment, but does not include psychotherapy notes. Non-health information, includes earnings, financial or credit history, professional licenses, employment history or any other facts deemed necessary by Colonial Life to evaluate my application or claim forms.

Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits or for evaluating my eligibility for insurance, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms. Some information, once obtained, may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Colonial Life will not re-disclose the information unless permitted or required by those laws or as authorized by me.

I also authorize Colonial Life to disclose my information to the following persons (for the purpose of reporting claim status, or experience, or so that the recipient may carry out health care operations, claims payment, administrative or audit functions related to any benefit, plan or claim): any employee benefit plan sponsored by my employer; any person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Colonial Life; or, the Social Security Administration. Colonial Life will not condition the payment of insurance benefits on whether I authorize Colonial Life to re-disclose my information. For the purposes of these disclosures by Colonial Life, this authorization is valid for one year or for the length of time otherwise permitted by law.

This authorization is valid for two (2) years from its execution or the duration of my claim (to include any subsequent financial management and/or benefit recovery review), whichever is earlier, and a copy is as valid as the original. I know that I, or my authorized representative, may request a copy of this authorization. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial Life has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I do not sign this authorization or if I alter or revoke it, except as specified above, Colonial Life may not be able to evaluate my claim or eligibility for insurance. I may revoke this authorization by sending written notice to the Claims Department at the address listed above.

_____ _____

Signature Date signed (MM/DD/YYYY)

_____ XXX-XX-_____ _____

Printed name of individual subject to this disclosure Last four digits of SSN Date of birth (MM/DD/YYYY)

If applicable, I signed on behalf of the insured as _____ (indicate relationship). If legal guardian, power of attorney designee, conservator, beneficiary or personal representative, please attach a copy of the document granting authority.

_____ _____ _____

Printed name of legal representative Signature of legal representative Date signed (MM/DD/YYYY)