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## Life Claim Statement Employee/Employer

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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.***

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Fortis Benefits Insurance Company. In this document, the terms "we," "us," "our," and the like, refer to each as applicable.

## 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 1-800-451-4531 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:

1-816-881-8967

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 1-800-451-4531.**

**Employer Information**

1. Employer's name and full address ( <i>Please print.</i> )		2. Group Policy no.	
3. Name of Administrator		4. Telephone no.	
5. Employer e-mail address		6. Fax. no.	

AUTHORIZED SIGNATURE OF THE POLICYHOLDER WITH NO FINANCIAL INTEREST IN THE CLAIM  
I certify that the information provided is true to the best of my belief and knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Employee Eligibility**

1. Full name of insured ( <i>Please print.</i> )		2. Certificate no.	
3. Date of birth	4. Date of death	5. Social Security no.	
6. Legal residence at the time of death ( <i>street, city, town, state, zip code</i> )			

**Employee Information**

1. Hire date	2. Date insurance effective	3. Job title	
4. Hours worked per week	5. <input type="checkbox"/> Full time <input type="checkbox"/> Part time	6. Last day worked	
7. Base salary as of last day worked		Reason: <input type="checkbox"/> Illness <input type="checkbox"/> Layoff <input type="checkbox"/> Retired <input type="checkbox"/> Leave of absence <input type="checkbox"/> Disabled <input type="checkbox"/> Other _____	
8. Date of last increase			
9. Due date of last premium paid			

**Type and Amount of Claim**

- |   |                |                       |
|---|----------------|-----------------------|
| <input type="checkbox"/> Employee Life            | \$ _____ basic | \$ _____ contributory |
| <input type="checkbox"/> Accidental Death         | \$ _____ basic | \$ _____ contributory |
| <input type="checkbox"/> Dependent Life           | \$ _____ basic | \$ _____ contributory |
| <input type="checkbox"/> Accidental Dismemberment | \$ _____ basic | \$ _____ contributory |

**Failure to provide complete information 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.**