UnitedHealthcare Insurance Company

UnitedHealthcare Specialty Benefits
PO Box 7149
Portland, ME 04112-7149
1-888-299-2070
Fax: 1-800-980-0298

UnitedHealthcare Specialty Benefits

REQUEST FOR GROUP LIFE INSURANCE BENEFITS

(PROOF OF DEATH FOR GROUP INSURANCE)

INSTRUCTIONS:

1. Claimant, please fill in and sign SECTION 1 below.
2. Please include a Certified Death Certificate
3. If death was the result of an accident, please include the following.
   - Copy of any police report
   - Copy of any toxicology report and autopsy report
4. Once completed, submit this form, along with any attachments to the Employer for completion of SECTION 2.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a notice of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

SECTION 1

CLAIMANT'S STATEMENT

Deceased's Name:	
Deceased's Address:	
Name of Insured Employee:	Deceased's S.S. Number:
Name of Employer:	Group Policy Number:
Deceased Date of BIRTH:	Deceased's Date of DEATH:
Place of Death (if in hospital, give name and address of hospital):	
Cause of Death:	

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SECTION 1 continued...

Your Name:	Your Date of Birth:	
State Your Relationship to Deceased:	Your Home Phone Number:	Your Cell Phone Number:
Your Address:		

By my signature below, I hereby certify the following:

- I have completed this form to the best of my knowledge and belief and the information it contains is true and complete.
- I agree that by furnishing this form and investigating the claim, UnitedHealthcare Insurance Company shall not be held to admit validity of any claim, or waive any of its rights, or any of the conditions of the policy.
- I authorize UnitedHealthcare Insurance Company to obtain any medical or hospital records on the deceased. A copy of this authorization will be as valid as the original.
- I authorize OptumHealth Bank, Inc., Member FDIC, ("Bank") to open an interest bearing deposit account in my name ("Account") and in the event that I am eligible and an Account is opened by the Bank, I hereby direct UnitedHealthcare Insurance Company to transmit all payable claim proceeds of $5,000 or more to such Account. I agree that if the payable proceeds are less than $5,000, or I am ineligible to open an Account with the Bank, I will, subject to the terms and conditions of the policy, receive a check directly from UnitedHealthcare Insurance Company for any benefit.
- I understand and agree that my Account will be established and governed by the Bank's Account Terms and Conditions, including the Bank's Privacy Policy, which will be given to me if and when my Account is opened.
- I understand that in conjunction with my Account, I will be issued a Wealth Management Account Debit MasterCard® ("Card") and hereby acknowledge that by using the Card to access my Account, I agree to abide by the terms and conditions of the Wealth Management Account Card Agreement provided to me with my Card.
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interests or dividends, or (c) the Internal Revenue Service has notified me that I am no longer subject to backup withholding.

Social Security Number or Taxpayer Identification Number | Signature | Date

PER THE USA PATRIOT ACT:

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. When you open the account, we will ask for your name, street address, date of birth and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

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SECTION 2

We certify that, to the best of our knowledge and belief, the following statements and answers are true:

EMPLOYER'S STATEMENT

Full Name of Employee

Address of Employee	Street Address		
	City	State	Zip
Employer			Group Policy Number

Employee Social Security Number

__ __ __ - __ __ - __ __ __ __

Date to which Employee's Individual Premiums are paid

Date of Employment

Date Deceased Last Present at Work

If Employee not actively at work on date of death, give reason:

☐ Discharged ☐ On Leave of Absence ☐ Quit ☐ On Vacation ☐ On Disability

☐ Temporary Work Stoppage

☐ Other, explain _____

Occupation or Class of Insured	Scheduled Hours Worked

Amount of Basic Life Insurance $_____

Amount of Supplemental Life Insurance $_____

Amount of Dependent Life Insurance $_____

Amount of Accidental Death and Dismemberment Insurance $_____

Name of Beneficiary *	Relationship

***Please attach any enrollment forms and beneficiary designations you retained.**

Provide Proof of Annual Earning if life insurance benefit is based on Annual Earnings.

Instructions: After completion of both sections of this form, PLEASE MAIL OR FAX to address/fax number shown on 1st section of this form. Be sure to include all supporting documents.

AUTHORIZED OFFICIAL MUST SIGN BELOW:

Name of Employer

Address of Employer

Telephone Number of Employer (with area code)

Signature of Employer

Printed Name of Signing Company Official