Death Benefit Proceeds Claim Package For Group Insurance

DTH-PRO-CLAIM (09/17)

300 Southborough Drive, Suite 200
South Portland, ME 04106
Phone: 1-888-862-5732
Fax: 1-866-376-9480

Documentation required to begin the claim review

What we Require from the Beneficiary:

- One original death certificate.
- A completed Death Benefit Proceeds Form from each beneficiary. If there are multiple beneficiaries, please photocopy the form or contact us for additional copies. (pages 4-5)
- A completed HIPAA compliant authorization form. (page 6)

What we Require from the Group Plan Administrator:

- A completed Employer's Statement. (page 2)
- A copy of the current beneficiary designation.
- Copies of all enrollment forms.
- If the claim is incurred during the first 3 months of coverage, payroll records and/or proof of active employment will be required.

How to return your Death Benefit Proceeds Kit

Please direct all Death Benefit Proceeds documents as a single package to:

AFLAC
300 Southborough Drive, Suite 200
South Portland, ME 04106

If your claim is approved

You will be mailed a check for the death proceeds.

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FRAUD NOTICE

Unless specific state language is provided below, the following general fraud notice applies: 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.

Arizona – 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.

Arkansas, Louisiana, New Mexico, West Virginia – 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.

California – 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."

Delaware, Florida, Idaho, Indiana, Oklahoma – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia, Colorado – 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.

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.

Maine, Tennessee, Virginia and Washington – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland, Alabama, Rhode Island and Texas - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
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.

Ohio – 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 is guilty of insurance fraud.

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 stated value of the claim for each such violation.

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EMPLOYER'S STATEMENT

please print clearly

The Employer Statement is to be completed by the group plan administrator.

1. General Information

Employer's Name			Group policy number
Employer contact (name of person completing this form)			Title
Employer's street address	City	State	Zip
Employer's email address	Telephone number	Fax number	

2. Employee Information

Employee's name (first, middle initial, last)	Gender ☐ M ☐ F	Social Security number	Date of Birth / /
Employee's street address	City	State	Zip

3. Dependent Information (*Complete only if submitting a dependent claim)*

Dependent's name (first, middle initial, last)	Gender ☐ M ☐ F	Date of Birth / /	Relationship to employee

4. Employment and Claims Information

Date hired / /	Effective date of insurance / /	Scheduled hours per week	Occupation
Date last actively at work *(as defined by policy)* / /		Reason for last day worked	
Date premiums terminated / /		Class *(as defined by policy)*	

5. Salary and benefits information

How was the employee paid? *(check one)* ☐ Hourly ☐ Salaried $ per hour:_____ $ per year:_____	Amount of coverage being claimed: Basic Life $_____ Supplemental / Voluntary Life $_____	What was the date of the last pay increase? / /

6. Beneficiary Designation

Current Beneficiary Designation Form is enclosed. ☐ Yes ☐ No

If not, please explain _____

7. Certification and Signature

I CERTIFY THAT THE ANSWERS I HAVE MADE TO THE ABOVE QUESTIONS ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I ACKNOWLEDGE THAT I HAVE READ THE FRAUD NOTICE ON THIS FORM.

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.

_____ Signature of Plan Administrator

_____ Date signed

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Beneficiary Instructions for completing Section 2 of the Death Benefit Proceeds Form

Please review the information below regarding section 2 of the Death Benefit Proceeds Form, and use it to determine the capacity under which you are making a claim for benefits. If supporting documentation is requested under the applicable capacity for which you are filling this claim, please submit all relevant documents.

Section 2 of the Death Benefit Proceeds Form: Capacity under which you are making this claim

Below is information regarding the different beneficiary types and what information is needed to complete this form.

Individual Beneficiary: A person claiming on their own behalf. If you request benefits to be paid to a funeral home, a copy of the assignment is required. Enter your Social Security Number in the Income Tax Certification in Section 2 and sign Section 4 (Beneficiary Signature).

Custodian/Guardian/Conservator/Power of Attorney: Payments on behalf of a minor must be made to an authorized representative of the minor, such as (i) a Custodian under the Uniform Transfers/Gifts to Minors Act, or (ii) a court designated Guardian of the "Person and Estate" or "Estate" of the minor. The legal representative must enter the minor's Social Security Number in the Income Tax Certification in Section 2, and sign Section 4 (Beneficiary Signature).

Payments may be made to other authorized beneficiary representatives, such as a Conservator of an incapacitated beneficiary under a court appointed conservatorship, or delivered to an Attorney in Fact under a Power of Attorney. A copy of the applicable Conservatorship papers or Power of Attorney is required. The legal representative must enter the beneficiary's Social Security Number in the Income Tax Certification in Section 2, and sign Section 4 (Beneficiary Signature).

Corporate Officer: Enter the corporate Taxpayer Identification Number in Section 2. Section 4 (Beneficiary Signature) must be signed by the corporate officers listing their respective titles.

Estate Executor: Be sure to submit a copy of the certified appointment papers and provide the estate Taxpayer Identification Number in Section 2. Section 4 (Beneficiary Signature) must be signed by an estate representative.

Trustee: A copy of the trust or amendments may be required. Provide the trust Taxpayer Identification Number in Section 2 and complete the Confirmation of Trust form. Section 4 (Beneficiary Signature) of the Death Benefit Proceeds Form and the Confirmation of Trust must be signed by all the trustees.

Collateral Assignee: A copy of the assignee's statement of interest must be provided. Section 4 (Beneficiary Signature) must be signed by the assignee or his/her authorized representative.

***Note: All non-individual beneficiaries must also complete and submit Form W-9. Failure to submit this requirement may result in 30% withholding on miscellaneous interest earned and/or taxable gain.**

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DEATH BENEFIT PROCEEDS FORM

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The Death Benefit Proceeds Form is to be completed by the beneficiary of the benefit proceeds.

1. Deceased Insured

Name of Deceased (First, Middle, Last) | Nickname or Maiden Name

Date of Birth / / | Date of Death / / | Deceased's Social Security Number ☐☐☐☐☐☐☐☐☐

Cause/Manner of Death

Natural *(check one)*
☐ Cancer ☐ Heart Disease
☐ Respiratory Disease
☐ Other _____

If not Natural *(check one)*
☐ Accident ☐ Suicide
☐ Homicide ☐ Unknown
☐ Other _____

State/Country of Residence at Time of Death

2. Beneficiary Information

Capacity under which you are making this claim CHECK ONE Refer to the Instructions Page for Descriptions

☐ Individual Beneficiary ☐ Custodian/Guardian/Conservator/Power of Attorney ☐ Corporate Officer
☐ Estate Executor ☐ Trustee ☐ Collateral Assignee

Name of individual completing the form if other than the beneficiary | Gender ☐ Male ☐ Female

Beneficiary Name (Individual, Minor, Corporation, Estate or Trust)

Relationship to Insured
☐ Spouse ☐ Child ☐ Grandchild ☐ Parent ☐ Sibling ☐ Other _____

Date of Birth / / | Daytime Phone | Email

Residential Street Address | City | State | Zip

Mailing Street Address *(if different than residential address)* | City | State | Zip

Income Tax Certification

Enter your **Social Security number** if you are an individual beneficiary ☐☐☐☐☐☐☐☐☐

OR

Enter **Taxpayer Identification number** if claiming benefits as an estate, trust or corporation ☐☐☐☐☐☐☐☐☐

3. Children Certification

Complete this section if you have been informed there are other minor beneficiaries for which you are not the parent or guardian. Please list all children below. Attach an additional page if needed.

Name (First, Middle, Last)	Date of Birth / /	Parent 1/Guardian 1
Address	Date of death *(if applicable)* / /	Parent 2/Guardian 2
Name (First, Middle, Last)	Date of Birth / /	Parent 1/Guardian 1
Address	Date of death *(if applicable)* / /	Parent 2/Guardian 2

See next page for your Required Signature

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4. Beneficiary Signature

Under penalties of perjury, I certify that: (1) my Social Security Number or Tax ID Number shown on this form is my correct taxpayer identification number, (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding; or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividend income; or (c) the IRS has notified me that I am no longer subject to backup withholding, (3) I am a U.S. person (includes a U.S. resident alien) and (4) I am exempt from Foreign Account Tax Compliance Act (FATCA) reporting.

☐ Check this box if the IRS has notified you that you are subject to backup withholding.

If I am not a U.S.citizen, U.S. resident alien or other U.S. person, I am submitting the applicable Form W8 with this form to certify my foreign status and, if applicable, claim treaty benefits.

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

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. Please refer to the enclosed page entitled FRAUD NOTICE for specific notices required in certain jurisdictions.

_____ Date: _____/_____/_____

Signature *(Required)* **Month** **Day** **Year**

_____

Name *(Printed)*

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HIPAA COMPLIANT AUTHORIZATION

To expedite the processing of your claim, please complete this page in its entirety.

I give my permission to release information concerning

Name of Insured (First, Middle, Last)	Insured's Date of Birth / /	Insured's Social Security Number
Policy Number(s)		Date of Death / /

to Aflac, including its agents, affiliates, subsidiary companies, attorneys, reinsurers, insurance support organizations and independent administrators who are acting on its behalf ("Aflac"). Information released may include records of medical advice, medical care, medical treatment relating to the Insured's physical or mental condition including, but not limited to, AIDS and AIDS-related diseases, mental illness, and drug or alcohol use, but excluding psychotherapy notes. Information released may also include autopsy, toxicology and investigation reports; accident reports made by ambulance personnel, law enforcement or paramedics; and information about other insurance coverage, financial and employment history, driving records or information otherwise needed to determine claim benefits due. This information may be released by medical professionals or facilities; pharmacies; pharmacy benefit managers; laboratories; government offices including, but not limited to, departments of motor vehicles, the Social Security Administration, Internal Revenue Service and Veteran's Administration; employers; insurance companies; insurance support organizations; group policyholders and benefit plan administrators; consumer reporting agencies; financial institutions and any other organization having any knowledge of the above-named Insured. When requesting information from any of the sources named above, a copy of this form is as valid as the original. I am aware that any information obtained will be used to evaluate my claim.

Either I, or a person I choose, am entitled to receive a copy of this authorization. This authorization is valid for one year from the date signed.

I have the right to revoke this authorization at any time by notifying Aflac in writing at the address on this authorization. My revocation will not be effective to the extent Aflac or any other person already has disclosed or collected information or taken other action in reliance on this authorization. My revocation will also not be effective to the extent state law gives Aflac the right to contest a claim under the policy or the policy itself.

The information Aflac obtains based on this authorization may be subject to further disclosure and no longer protected by HIPAA.

_____ Date: _____/_____/_____
Signature of Authorized Representative* Month Day Year

_____
Relationship to Insured

***Authorized Representative must provide proper documentation, such as Estate representation documents.**

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MEDICAL INFORMATION AND INSURANCE

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The Medical Information and Insurance Form is to be completed by the beneficiary of the benefit proceeds.

Complete this section in its entirety ONLY (a) if the death was due to an accident and the policy contains the Accidental Death Benefit; or (b) if specifically requested.

1. Other Life Insurance coverage in effect for the Insured

Name of Insured (First, Middle, Last)	Insured's Date of Birth / /	Insured's Social Security Number
Policy Number(s)		Date of Death / /

2. Physicians and Hospitals where the Insured was treated

Provide the names and addresses of all physicians and hospitals who treated the insured within the last 5 years.
If necessary, use an additional sheet of paper.

Physician/Hospital Name				
Address		City	State	Zip
Telephone	Dates treated / /	Condition		
Physician/Hospital Name				
Address		City	State	Zip
Telephone	Dates treated / /	Condition		
Physician/Hospital Name				
Address		City	State	Zip
Telephone	Dates treated / /	Condition		

3. Health Insurance policies that covered the Insured

Please list all health insurance carriers during the past 5 years. If necessary, use an additional sheet of paper.

Company Name	Policy Number	Effective Dates / /	Phone Number
Address	City	State	Zip
Company Name	Policy Number	Effective Dates / /	Phone Number
Address	City	State	Zip
Company Name	Policy Number	Effective Dates / /	Phone Number
Address	City	State	Zip

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CONFIRMATION OF TRUST

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Complete ONLY if beneficiary of policy is a TRUST.

A copy of the Title, Signature, and Notary pages of the trust agreement, including the pages showing the trustee and successor trustee information may be required.

1. Policy Numbers

2. Trust Information

Deceased Annuitant/Insured Name (First, Middle, Last)

Name of Trust

Date of Trust Agreement	Tax Identification Number	State where trust was established
/ /		

Please select the statement below that applies:

☐ The undersigned trustee(s) hereby certifies/certify that no oral or written notification has been received that the trust agreement dated

_____/_____/_____

has been revoked or amended.

or

☐ The undersigned trustee(s) hereby certifies/certify that the trust agreement dated

_____/_____/_____

has been revoked.

or

☐ The undersigned trustee(s) hereby certifies/certify that the trust agreement dated

_____/_____/_____

was last amended on

_____/_____/_____.

If there are additional amendments, please provide all dates.

Was this trust created as a grantor trust for federal income tax purposes? ☐ Yes ☐ No

3. Successor Trustee

If acting as successor trustee(s), please also complete the following statement:
The undersigned successor trustee(s) hereby certifies/certify that the original trustee(s),

_____ is/are no longer serving as trustee(s).
Original Trustee(s) Name(s)

4. Trustee Signature

I/We certify that the right to serve as trustee(s) has not been revoked or renounced. The following signatory(s) has/have been appointed as trustee(s) and is/are the only acting trustee(s) for the aforementioned trust agreement.

Trustee Name *(please print)*	Trustee Signature	Date