Dearborn National®

Death Claim Form
Group Life and Accidental Death Insurance

Return to Dearborn National at:
Attention: Claims Department
1020 31st Street
Downers Grove, IL 60515-5591

Phone Number: (800) 778-2281
Fax: (312) 540-4706

INSTRUCTIONS

The employer/administrator must complete the claim form as indicated and send attachments mentioned below. We will advise you if further documentation is necessary to complete the claim process.

Please submit the following documentation:

1. Death Claim Form:
   Part 1 – Completed by the Employer/Administrator
   Part 2 - Completed by the Beneficiary(ies)

2. Original, photocopy or screen print of enrollment form, including any beneficiary changes.

3. A copy of the final certified official death certificate.

4. If the benefits are based on salary, payroll records verifying the insured's annual earnings at the time of death.

5. If any portion of coverage is paid for by the insured, proof of payroll deduction.

6. For accidental death benefits, provide the following:
   a. Official completed police report
   b. Proof of seatbelt/airbag use if applicable
   c. Newspaper clipping(s) of accident, if applicable
   d. Coroner's report, findings and/or toxicology report

7. If the Beneficiary is:

   a. A minor, an estate or incompetent to handle financial matters: provide an original court order appointing a legal representative or guardian to handle the financial affairs of the minor, the estate, or the incompetent.
   b. Deceased: provide proof of death, a copy of the final certified death certificate, and documentation of the secondary beneficiary.
   c. A trust: provide documentation verifying existence of the trust, documentation that the trust has been named the beneficiary, and the tax identification number of the trust.

8. Each beneficiary must complete and sign the Beneficiary/Claimant Statement. The Beneficiary / Claimant Statement contains information about the Dearborn National Freedom Account. For benefit amounts of $10,000 or more the benefits will be placed in the Dearborn National Freedom Account in the beneficiary's name. Please see page 4 for further details.

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Part 1 – To be completed by Employer/Administrator

Statement of Employer

Employer/Plan Information

Group Name _____ Subsidiary Name _____

Group Number _____Account #/Division#_____

Is this insurance part of an ERISA plan? ❑ Yes ❑ No Is the group a labor union? ❑ Yes ❑ No

Address: _____ _____ _____
Street City State/Zip

Name and Title of Authorized Representative _____

Phone Number _____ Fax Number _____

E-Mail Address _____

Preferred communication: ❑ email ❑ phone ❑ fax

Deceased Person Information

Name _____Relation to Employee/Member_____
(include Death Certificate)

Insured Information

Name _____Social Security No._____

Class_____DOB: _____ Hire Date _____ Occupation _____

Insurance Effective Date or Credits accumulated _____ Date of last premium Contribution _____

Annual Salary _____ Date of Last Salary Increase _____ Work Schedule _____hrs/wk
(If salary based benefit or if any portion of premium is contributory please submit proof of payroll deduction)

Last Day Worked _____ Reason for stopping work: _____(resignation,

disability, retirement, illness, layoff, leave of absence, vacation, other)_____

If retired, date of retirement _____ If terminated, date of termination _____

If Disabled, provide date of disability _____ Waiver of Premium ❑ Yes ❑ No
Continuation of Life Insurance ❑ Yes ❑ No Extended Life? ❑ Yes ❑ No

Beneficiary/Informant (include address and phone #):_____

Online beneficiary tracking? ❑ Yes ❑ No Tracking System_____

Coverages

Amount of Insurance:			Additional Benefits:	
	Basic Life	_____		Seat Belt _____
	Supplemental Life	_____		Air Bag _____
	AD&D	_____		Critical Illness _____
	Voluntary Life	_____		Education _____
	Dependent Life	_____		Other _____

If deceased is a dependent child, please complete the following:

Dependent child's date of birth:_____
Is he/she a full-time student? ❑ Yes ❑ No Name of School _____
Is he/she incapacitated and reliant on the employee for financial support? ❑ Yes ❑ No

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Signature of Authorized Employer/Plan Representative _____

Print Name _____ Date _____

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MEMBER/EMPLOYEE:_____ SSN#_____

Part 2 – To be completed by Beneficiary

***If there is more than one beneficiary, each must complete a separate form. See Instruction page If beneficiary is a minor.**

Name _____
Last First Middle

Date of Birth _____ Social Security No. _____

Address _____
Street City State Zip

(PO Box not acceptable for benefits provided through a Dearborn National Freedom Account.)

Phone _____ E-mail _____

Relationship to deceased _____ Comments:_____

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Signature of Beneficiary _____

Print Name _____ Date _____

IRS Certification

Are you a U.S. Citizen: ❑ Yes ❑ No (If No – IRS Form W-8 required) Provide other work ID if available:_____

Under penalty of perjury, I certify that:

1. The number shown on this form is my correct Social Security/Taxpayer Identification number; and
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 Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person.

NOTE: Certification Instructions – You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. If you fail to certify, we may be required to withhold federal and state tax.

Your Signature _____ Date _____

Printed Name _____

Phone Number: (800) 778-2281
Fax: (312) 540-4706

Return to Dearborn National at:
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1020 31st Street
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Method of Payment

Dearborn National® Freedom Account*

If your benefit payment is scheduled to be $10,000 or more, Dearborn National will establish an interest bearing account in your name. The Freedom Account earns interest beginning on the day it is opened. Interest is compounded daily and credited to your account each month. Your monthly statements will provide additional details on your balance. You have immediate access to your benefit funds or you may leave them in the account while you take time to weigh the important financial decisions that often follow a life changing event.

Once your claim is approved, you will receive a draft book and an implementation kit within 72 hours explaining the benefits of the Freedom Account. Your implementation kit includes:

- A copy of the required Privacy Letter outlining the steps we take to ensure your privacy.
- An Information Booklet containing information and frequently asked questions about the Freedom Account including a phone number you can access 24 hours a day for additional information.
- A Certificate of Confirmation containing information on your account and the benefit amount that was placed into the account.

While not insured by the Federal Deposit Insurance Corporation (FDIC), all amounts in the account are fully protected and guaranteed by Fort Dearborn Life Insurance Company, an underwriting company of the Dearborn National brand.

*Not available for residents of Rhode Island. Not available if claimant/insured is a minor, legally incompetent, or otherwise under the care of a guardian.

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MEMBER/EMPLOYEE:_____ SSN#_____

AUTHORIZATION FOR RELEASE OF INFORMATION (We will require a separate authorization for release of psychotherapy notes.)

I (the undersigned) authorize _____(physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; coroner's office; insurance or reinsurance company; government agency; department of labor; law enforcement or public safety department; group policyholder; employer; or policy or benefit plan administrator) to release information from the records of:

Deceased's Name: _____
Last First Middle

Claimant/Insured Information to be released:

- Data or records regarding medical history, treatment, prescriptions, consultations, autopsy (including medical reports; records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition(s));
- Any information regarding insurance coverage; and
- Accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).
- Information to be released to: Dearborn National
  1020 31st Street
  Downers Grove, IL 60515

- I understand the information obtained by use of this Authorization will be used by Fort Dearborn Life Insurance Company (the Company) to evaluate my claim for death benefits. The Company will only release such information:
  - To its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
  - As may be required by law; or
  - As I further authorize.
- I further understand that refusal to sign this Authorization may result in the denial of benefits.
- I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- I understand that I may revoke this Authorization in writing at any time, except to the extent the Company has taken action in reliance on this Authorization. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signature below. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.
- A photocopy of this Authorization is to be considered as valid as the original.
- I understand I am entitled to receive a copy of this signed Authorization.

SIGNATURE (CLAIMANT OR REPRESENTATIVE): _____

DATE: _____ PRINT NAME: _____

Relationship to Claimant or description of authority to act if you are the personal or legal representative of the Claimant: _____. If you are the legal representative of the Claimant we may ask for additional documentation.

ADDRESS: _____ PHONE NO. _____
Street

_____
City State Zip

Dearborn National®

Fraud Notices

Administrative Offices: **Downers Grove, Illinois I Dallas, Texas**

The laws of some states require us to furnish you with the following notice:

FOR APPLICATIONS AND CLAIMS:

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: 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.

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.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Louisiana: 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.

Maine & 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 include imprisonment, fines and denial of insurance benefits.

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

New Mexico: 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 civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowingly 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.

Oklahoma: Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

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 dollars($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be 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.

Rhode Island: 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.

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

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

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The laws of some states require us to furnish you with the following notice:

FOR CLAIMS ONLY:

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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: 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 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: 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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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.

Texas: 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.

FOR APPLICATIONS ONLY:

Massachusetts: 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.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.