USAble Life

Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (501) 375-7200
Fax (501) 399-3806

Proof of Death

For H.O. Use Only
Eff _____
PTD _____
Benefits _____

DEATH OF AN INSURED EMPLOYEE

Important: Read Carefully

WARNING: It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

This form is to be completed upon the death of an insured and forwarded to USAble Life. In addition, an official Certified Death Certificate is required. If death was due to suicide, homicide or accidental means, a copy of the investigating officer's report is also required. By furnishing this form and investigating the claim, USAble Life shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.

EMPLOYER'S STATEMENT

USAble Life's Group Number	Certificate/ID Number	
Name of Employee	Date of Birth	Date of Death
Address	City, State, Zip	
Date Employed	Date on which employee was last "actively at work"	

Reason Employee stopped work ☐ Death ☐ Disability ☐ Retirement ☐ Termination of Employment

Date on which employment terminated _____

Claim is for (check all applicable)

☐ Basic Group Term Life Amount $ _____ ☐ Accidental Death Amount $ _____

☐ Supplemental/Vol. Group Term Life Amount $ _____ ☐ Optional SeatBelt Rider (if applicable) Amount $ _____

1. Did the deceased die in a motor vehicle accident? ☐ Yes ☐ No
   If yes, was the deceased wearing a seat belt? ☐ Yes ☐ No
2. Do you recommend payment of this claim? ☐ Yes ☐ No

Employer	Telephone ( )	
Signature	Title	Date
Name (Please print or type)	Fax Number ( )	
Address	City, State, Zip	

AUTHORIZATION TO OBTAIN INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of the deceased or his health, past or present, to furnish such information to USAble Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original.

FRAUD WARNING: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Date _____ Signature of Nearest Relative _____ Relationship To Deceased _____

BENEFICIARY'S STATEMENT

I certify that the information furnished in support of this claim is true and correct.

Beneficiary's Name (Please print) _____ Relationship To Deceased _____

Beneficiary's Date of Birth _____ Beneficiary's Social Security # _____ Daytime Telephone _____

Address _____ City, State, Zip _____

Date _____ Beneficiary Signature _____

(See Page 2/reverse side for death of an insured dependent.)

USAble Life

Proof of Death

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DEATH OF AN INSURED DEPENDENT

Important: Read Carefully

WARNING: It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

This form is to be completed upon the death of an insured and forwarded to USAble Life. In addition, an official Certified Death Certificate is required. If death was due to suicide, homicide or accidental means, a copy of the investigating officer's report is also required. By furnishing this form and investigating the claim, USAble Life shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.

EMPLOYER'S STATEMENT

USAble Life's Group Number	Certificate/ID Number	Date of Death
Name of Employee	Name of Deceased Dependent	

Dependent Life Amount being claimed $_____ Do you recommend payment of this claim? ☐ Yes ☐ No

Employer	Telephone ( )	
Signature	Title	Date
Name (Please print or type)	Fax Number ( )	
Address	City, State, Zip	

EMPLOYEE'S STATEMENT

Deceased's Relationship to Employee	Deceased's Date of Birth

If relationship is shown to be "child," was deceased married at the time of death? ☐ Yes ☐ No

If relationship is shown to be "spouse," was deceased divorced or legally separated from you? ☐ Yes ☐ No

Was the deceased a dependent and used by you as such for income tax purposes? ☐ Yes ☐ No

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of the deceased or his health, past or present, to furnish such information to USAble Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original.

FRAUD WARNING: Except as noted in separate Fraud notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Date _____ Employee's Signature _____ Employee's Social Security # _____

Address _____ City, State, Zip _____ Daytime Telephone _____

(See Page 1/reverse side for death of an insured employee.)

FRAUD NOTICE

For your protection, the laws of some states may require us to furnish you with the following notice:

Except as otherwise noted below, it is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Arizona
Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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.

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

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

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.

Retain for your records.