UnitedHealthcare Insurance Company

UnitedHealthcare Specialty Benefits
PO Box 7149
Portland, ME 04112-7149
1-888-299-2070
Fax: 1-800-980-0298
Unsecured E-mail: FPCustomerSupport@uhc.com

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 finalized 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.

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:

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

Your Address:

UnitedHealthcare Insurance Company

UnitedHealthcare Specialty Benefits
PO Box 7149
Portland, ME 04112-7149
1-888-299-2070
Fax: 1-800-980-0298
Unsecured E-mail: FPCustomerSupport@uhc.com

UnitedHealthcare®

INSTRUCTIONS:

1. Employer, please fill in and sign SECTION 2 below.
2 Please attach any enrollment forms and beneficiary designations you retained.
3 Please provide Employee's time records for 12 weeks prior to last day worked.
4 After completion of both sections of this form, please MAIL, EMAIL or FAX (see above) all supporting documentation.

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	
Employer Address		Phone Number	
Employee Social Security Number		Date of Employment	
Date to which Employee's Individual Premiums are paid			
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 Voluntary Life Insurance	$_____
Amount of Dependent Life Insurance	$_____
Amount of Accidental Death and Dismemberment Insurance	$_____
Amount of Voluntary Accidental Death and Dismemberment Insurance	$_____

Name of Beneficiary	Relationship

Proof will include Employee's Payroll Records for 12 weeks prior to last day worked. If the benefit is based on Annual Earnings or prior year W-2, then submit this information with the Life claim.

Final Signature and Certification

Name of person completing this form	E-mail address	
Title	Phone number	Ext
Signature eSignature is allowed)	Date Signed	

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For claimants in Alabama:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

For claimants in 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.

For claimants in 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.

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.

For claimants in 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.

For claimants in Connecticut:
Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

For claimants in 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.

For claimants in 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.

For claimants in 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

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

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

For claimants in 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.

For claimants in Kansas:
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 may be guilty of fraud as determined by a court of law.

For claimants in 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.

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For claimants in Maine:
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.

For claimants in Maryland:
Any person who knowingly or willfully presents a false or fraudulent claim for payment for 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.

For claimants in Minnesota:
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For claimants in 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.

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

For claimants in 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 penalties.

For claimants in 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.

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

For claimants in Oregon:
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 may be guilty of a crime and may be subject to fines and confinement in prison.

For claimants in 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.

For claimants in Tennessee 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 include imprisonment, fines and denial of insurance benefits.

For claimants in 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 claimants in Vermont:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

For claimants in Virginia:
Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete, or misleading information may have violated state law.

For claimants in All Other States:
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.

UnitedHealthcare Specialty Benefits

PO Box 7466 Portland ME 04112-7466
Tel 888 299 2070
Fax 888-505-8550

Claims Department
Direct Deposit Agreement
For Payment of Benefit to Financial Institution

Section 1 (to be completed by benefit recipient)

Name of Benefit Recipient

UHCSB Claim Number

UHCSB Policy Number

Social Security Number

Telephone Number

Address (Number, Street, Route, P.O. Box, APO/FP, including directional such as NE, NW, SE, SW etc)

City

State

Zip (preferably the nine digit ZIP code)

"I authorize UnitedHealthcare Specialty Benefits to direct the net amount of my benefit payment to be deposited directly by electronic funds transfer and credited to my account as indicated at the financial institution designated below. If any payments made are dated after the date of my death, I hereby authorize and direct the said financial institution on my behalf and on behalf of my executors or administrators to refund any such payments to UnitedHealthcare Specialty Benefits and to charge the same to my account."

Signature of Benefit Recipient (eSignature is allowed)

Date Signed

Section 2

Name of Financial Institution

Address ((Number, Street, Route, P.O. Box, APO/FP, including directional such as NE, NW, SE, SW etc)

City

State

Zip (preferably the nine digit ZIP code)

Routing Number (9 digit number in lower left corner of check)

Bank Account Number (numbers following the Routing Number)

Type of Account ☐ Checking ☐ Savings (check one)

UnitedHealthcare Insurance Company

UnitedHealthcare Specialty Benefits
PO Box 7149
Portland, ME 04112-7149
1-888-299-2070
Fax: 1-800-980-0298
Unsecured E-mail: FPCustomerSupport@uhc.com

UnitedHealthcare®

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 Optum Bank, 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 and the Bank's Schedule of Fees, which I have received.
- 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.
- I acknowledge that I have read the applicable Fraud Warning Notices provided with this claim form.

☐ **Please check this box if you prefer payment of proceeds via check directly to you versus the account referenced above.**

PLEASE sign your name as it appears on your Social Security Card in order to avoid delays in processing.

_____	_____	_____
Social Security Number or Taxpayer Identification Number	**PLEASE SIGN AND DATE IN INK**	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.