

**EMPLOYEE DEATH CLAIM FORM
GROUP INSURANCE**



P.O. BOX 7777 - MERIDIAN, IDAHO 83680-7777 (800) 657-6351

By furnishing this form and investigating the claim the Company shall not be held to admit validity of any claim or to waive the breach of any condition of the policy. The Company reserves the right to require and obtain such additional statements and information as it deems necessary.

1. Employer		2. Employer Telephone #		3. Group Policy Number	
4. Employee's Name		5. Social Security #	6. Sex	7. Date of Birth	
<p>In order to help us find all potential benefits available, please answer the following:</p> <p>1. Has the deceased ever been known by another name, nickname, alias or has his/her name ever been spelled any other way? _____ No _____ Yes. If so, please list here: _____</p> <p>2. List all policy numbers or coverage provided by any United Heritage Financial Group product (Individual, Group, Property/Casualty or Financial Services). _____</p>					
8. Residence (Street, City, State, Zip Code)			9. Date Employed	10. Occupation	
11. Wage or Salary		12. Amount of Insurance		13. Last Change in Amount of Insurance Decrease \$ _____ Date of Change _____ Increase \$ _____	
14. How many hours per week did the employee work immediately prior to his death or total disability?			15. How many weeks did the employee work in the 52 weeks immediately prior to his death or total disability?		
16. Original Effective Date of Deceased's Insurance		17. Most Recent Effective Date, if different		18. Date last worked Full Time	
19. Reason for leaving work: () Disability (including Disability Leave of Absence) () Leave of Absence (other than disability) () Quit () Retired () Dismissed () Vacation () Temporary Layoff () Other _____					
20. Date of Death		21. Cause of Death, if known			
22. Was Insured considered an employee at date of death? () YES () NO If no, explain					
23. Was coverage terminated prior to death? () YES () NO If Yes, Date of Termination _____			24. Was claim for disability submitted prior to death? () YES () NO		
25. Was Death due to an accident? () YES () NO if Yes, a. Was death due to an injury arising out of and during the course of employment? _____ b. What was insured doing when the injury occurred? _____ c. Describe how the injury occurred _____ d. If an automobile accident, was the Insured wearing a seat belt? _____					
26. Name of Beneficiary		Relationship		Age	
27. Address of Beneficiary (Street, City, State, Zip Code)					
28. Did the Insured have Dependent Life Insurance? () YES () NO			29. Mode of Settlement desired? (See Group Policy for Settlement Provisions)		
30. Please furnish any other information that may help in processing this claim.					

We believe that this employee was eligible and insured under the provisions of the group policy and as indicated by the information shown above.

Employer _____

Date _____

By _____

Title _____

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INSTRUCTIONS

As soon as you learn of the death of an employee:

1. Complete and mail this statement with any insurance records that pertain to the employee to United Heritage Life Insurance Company, P.O. Box 7777, Meridian, Idaho 83680-7777. This should include:
 - a. Enrollment card.
 - b. Beneficiary changes.
 - c. Any additional information that would have a bearing on the payment of the claim.

2. Obtain from the beneficiary and mail to the above address:
 - a. Certified copy of the death certificate.
 - b. The certificate of insurance, if available.
 - c. If accidental death benefits will be claimed, send available newspaper clippings.

If insurance proceeds are payable to an estate, send a certified copy of the appointment and qualification of the administrator or executor.

If insurance proceeds are payable to a minor or mentally incompetent person, send a certified copy of the appointment of a guardian of the estate or property of the minor child or incompetent person.

If the designated beneficiary is deceased, send a certified copy of his/her death certificate.

United Heritage Life Insurance Company reserves the right to require and obtain such additional statements and information as it deems necessary.

The laws of some states require us to furnish you with the following notice: It is unlawful to knowingly file a claim statement that provides materially 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. The company is required to report suspected fraudulent activity to the Department of Insurance or appropriate regulatory authorities.

For residents of Arkansas, New Mexico, and Louisiana: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to California Residents: 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 residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading 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 its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to any insurance settlement or award shall be reported to the Colorado Division of Insurance.

Notice to Oklahoma Residents: "WARNING: 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 any false, incomplete or misleading information is guilty of a felony."