United of Omaha Life Insurance Company
A Mutual of Omaha Company
Group Life Claims

3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (800) 775-8805
Fax (402) 997-1835
Email submitgrplife@mutualofomaha.com

Instructions for Filing a Proof of Death Claim Form

Upon the death of an insured employee, plan member or insured dependent, the employer/plan administrator must complete the claim form as indicated and send attachments mentioned below. Be advised that further documentation might be necessary in the future to complete the claim process.

Please submit the required documentation:

1. Proof of Death claim form:

   Part I – Completed by the employer/plan administrator
   Part II – Completed by the beneficiary(ies)

2. Beneficiary Designation form, including beneficiary changes.

3. Original, photocopies or screen-print of enrollment form.

4. Original certified death certificate showing cause and manner of death. If the benefit amount is $200,000 or less, a copy of the death certificate showing cause and manner of death is acceptable.

5. For accidental death benefits, provide the following items, including but not limited to:

   a. Official investigative report (police, accident, fire, FAA, OSHA)
   b. Proof of seatbelt/airbag use, if applicable
   c. Coroner's report or Medical Examiner's report findings and/or toxicology report

6. If the beneficiary is:

   a. **An Estate** – We require the Letters Testamentary or Letters of Administration appointing the personal representative of the estate.
   b. **A Trust** – We require a copy of the following pages of the Trust – Face page of Trust, Trustee or Successor Trustee designation and Signature page of Trust.
   c. **A Minor** – According to state law, a minor lacks capacity to sign a binding release of an insurance contract.

      For this reason, life insurance benefits are not directly payable to a minor beneficiary. The following are options available when the beneficiary is a minor:

      1. **UTMA (Uniform Transfer to Minors Act)** – UTMA payment may be utilized providing that the benefit amount including interest is under the amount allowed for the minor beneficiary's state of residence.
      2. **Guardianship papers** – The minor's custodian may obtain formal guardianship papers for the minor's estate. These legal guardianship documents must be obtained prior to the release of the benefit.

7. If the beneficiary has predeceased the insured and no contingent beneficiary is named or the insured did not name a beneficiary:

   a. Payment of the life insurance benefits will be paid in order as specified in the policy provisions of the contract.
   b. The surviving heir must complete an Affidavit of Preferential Beneficiary Designation Form, which must be notarized.

The Proof of Death claim form should be returned to:

United of Omaha Life Insurance Company
Group Life Claims
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
or
Fax (402) 997-1835
Email submitgrplife@mutualofomaha.com

Fraud Warnings

The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

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.

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 and 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.

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.

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.

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.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an 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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any 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.

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

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 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 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.

Oklahoma: 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.

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, 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 include imprisonment, fines and denial of insurance benefits.

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.

If you live in a state other than mentioned above, the following statement applies to you: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.

Proof of Death Claim Form

Part I – To Be Completed by the Employer or Plan Administrator

The deceased is insured as: ❑ Employee/Member ❑ Spouse ❑ Child

1. Name of Claimant/Deceased___________________

   Name of Insured/Member (If not the deceased person) ___________________

2. Date of death ___________________ Date of birth___________________ Age________

3. Social Security Number of deceased___________________

4. Employee's/Insured's marital status:
   ❑ Single ❑ Married ❑ Widow/Widower ❑ Separated ❑ Divorced ❑ Domestic Partner ❑ Civil Union

5. Amount of insurance for the deceased:

   Basic Life___________________ Voluntary Life___________________

   Basic AD&D ___________________ Voluntary AD&D___________________

   Basic Dependent Life ___________________ Voluntary Dependent Life ___________________

   Voluntary Dependent AD&D ___________________

   If applicable attach enrollment record from when coverage was first elected (in written or electronic format).

6. Name of beneficiary as shown on your records ___________________ Relationship ___________________
   Attach a copy of the current beneficiary designation form (In written or electronic format).

7. Date on which the Employee was last present at work?___________________

8. For Dependent Claims – Is the Employee still actively working? ❑ Yes ❑ No If **No**, give employees last date of active work ____________

9. Reason for Employee/Insured ceased work:
   ❑ Illness (Including disability leave of absence/partial disability) ❑ Leave of absence (Other than disability)

   ❑ Quit ❑ Dismissed ❑ Vacation ❑ FMLA ❑ Retired (Date)___________________ ❑ Layoff

10. Was the Employee disabled? ❑ Yes ❑ No

    If **Yes**, date disability began ___________________ Date partial disability began___________________

11. Date premium for the above deceased has been paid through ___________________

12. Date of Hire___________________ ❑ Full Time ❑ Part Time

    ❑ Union ❑ non-Union ❑ Hourly ❑ Exempt ❑ non-Exempt ❑ Salaried

    Annual Salary (If salary based) $______________ Date of last salary increase___________________

    Average hours worked per week____________ Occupation______________________ Class____________

13. Effective date of deceased's insurance with Mutual of Omaha or United of Omaha ___________________

We hereby certify that to the best of our knowledge and belief, the above statements are correct and that said deceased's insurance was in force on the date of his or her death.

Group Policy Number ______________________ Name of Policyholder___________________

Printed name of authorized Employer/Plan Representative ___________________

Signature of authorized
Employer/Plan Representative ___________________ Date ___________________

Phone number ___________________ Email address___________________

Part II – To Be Completed by Beneficiary*

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

Name ____
(First) (Middle initial) (Last)

Beneficiary's Social Security Number or Taxpayer Identification Number____________________

Date of birth ______________ Home phone __________________ Cell phone __________________

Address ____

City ______________________ State ______________ ZIP Code ______________

Email address ____

Name of deceased______________________ Relationship to deceased ______________

Group policy number of deceased ______________________

Cause and manner of death, if known ______________________________

Was the death caused by an accident? ❑ Yes ❑ No
(If **Yes** and the policy includes an accidental death and dismemberment provision, we may require a copy of the Police/Accident Report, Autopsy/Medical Examiner's Report, Toxicology, and Death Certificate with cause and manner of death as accident.)

If you are not the named beneficiary, in what capacity do you make this claim?______________________

Does the deceased have any other life insurance coverage with Mutual of Omaha or United of Omaha? ❑ Yes ❑ No

If the deceased was a dependent fill out the following:

Was the dependent disabled? ❑ Yes ❑ No If **Yes**, describe the disability ______________________

Date disability began ______________________ Dependent's last day worked ______________________

Dependent's employer ______________________ Dependent's employer's phone number ______________

Is child: ❑ Full-time student ❑ Part-time student

Name & address of school____
(Street) (City) (State) (ZIP code)

Certification

In order for us to comply with applicable IRS reporting requirements, please complete the following certification:

Under penalty of perjury, I certify that:

a) The statements I have made on this form, including my Taxpayer Identification Number (or the fact that I am waiting for a number to be issued to me), are correct, and
b) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest and dividends, or the IRS has notified me that I am no longer subject to backup withholding.
c) I am a U.S. person.

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

Your signature ______________________________ Date ______________

Printed name ______________________________

Authorization to Release Personal Information

1. I (the undersigned) authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records containing the Personal Information of:

   Name of Claimant ____
   (Last) (First) (Middle)

   Date of Birth_____/______/_________ Social Security Number_______-______-_________

2. **Personal Information to be released:**
   - data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), X-rays, films or correspondence, and any medical condition I may now have or have had;
   - any information regarding insurance or benefit plan coverage, claims or benefits; and/or
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)

3. **You may release my Personal Information to:**
   ATTN: Group Life Claims
   United of Omaha Life Insurance Company
   3300 Mutual of Omaha Plaza
   Omaha, NE 68175-0001
   or Fax: 402-997-1835 or Email: submitgrplife@mutualofomaha.com

4. **I understand my Personal Information will be used by Mutual to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid. I also authorize Mutual to release my Personal Information as follows:**
   - to its reinsurer, or other persons or organizations performing business, legal or insurance support services in connection with my claim(s); or
   - to a vendor specializing in the application for Social Security Disability Benefits; or
   - to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
   - for self-insured disability plans only, to my employer; or
   - for fully insured plans to my employer for use in discussions with Mutual regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
   - as otherwise required or permitted by law or as I further authorize

5. I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

6. I understand that I may revoke this Authorization at any time by providing a written request to Mutual at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Mutual's receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 months after the date signed.

7. I understand that I am entitled to receive a copy of this Authorization and that a copy is as valid as the original.

RETAIN A SIGNED COPY FOR YOUR RECORDS

Name(s) used for records (if different than the name below): ______________________________

____

____ ______________________
Signature of Claimant Date

If Applicable: I am the legal representative of the Claimant and I am authorized to grant permission on behalf of the Claimant.

Printed Name of Legal Representative______________________________________

Signature of Legal Representative______________________________________

Type of Legal Representative ______________________________________

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

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Coping with Loss

Adjusting to losing a loved one

At times of grief and loss, it's not uncommon to be confused and uncertain about how to proceed.

We asked grief counselors, physicians and financial advisors what advice they would offer friends and clients during this difficult time. Some of their advice follows.

Grief & loss can affect your health

Be careful of your physical well-being, too. Your distress may manifest itself in sleeplessness and loss of appetite, adding to your emotional upset. The physical demands of added responsibilities may also take their toll. So, learn to ask for help and go easy on yourself.

Losing a loved one is one of life's most difficult trials

Each loss, like each relationship, is unique and each grief journey follows its own path and takes its own time. Strong emotions are natural and are a part of the healing process. Accepting those emotions and giving yourself permission to have them are important steps in the journey. Some mourners find solace in support groups or with professional counselors.

Finances

You may face major new financial responsibilities at this time. Not only must you put your own finances in order, but you may be called upon to make decisions regarding the estate of the deceased.

Do not give in to pressure to make snap decisions you might regret later. Protect yourself by consulting with the appropriate advisors, such as your accountant, attorney, insurance representative or financial planner.

Important Papers

If the deceased was your spouse, or you are executor of the estate, financial advisors suggest you search for important items and documents, including:

- Insurance policies
- Employee benefit plan documents
- Business agreements
- Wills/Trusts
- Income tax returns and W-2 forms
- Marriage and birth certificates

For Additional Assistance

For confidential assistance coping with grief and loss, reach a knowledgeable and understanding counselor, 24 hours a day, seven days a week at **1-800-238-1439.**

*Questions regarding your claim or claim status should be directed to 1-800-775-8805.

Access the complete Beneficiary Assistance brochure full of helpful information and advice at www.mutualofomaha.com/documents/cope-with-loss.pdf.

Insurance products and services are offered by Mutual of Omaha Insurance Company or one of its affiliates. Home office: 3300 Mutual of Omaha Plaza, Omaha, NE 68175. Mutual of Omaha Insurance Company is licensed nationwide. United of Omaha Life Insurance Company is licensed nationwide, except New York. Companion Life Insurance Company, Hauppauge, NY 11788-2937, is licensed in New York. Each underwriting company is solely responsible for its own contractual and financial obligations.