Assurity Life
Group Life Insurance
Claim Form

This form may be used for both employee and dependent death claims and employee accidental death claims.

Instruction to the Employer/Plan Administrator for Submitting a Death Claim

How to complete the Group Life Insurance Claim Form

1. **Complete Sections 1, 2, 3 and 4 of the Group Employer Statement portion of the Group Life Insurance Claim Form. In Section 3, complete (3A) if the claim is for an employee/member, or (3B) if the claim is for a dependent of an employee.**

   For Dependent Life coverage on dependents, the employee is always the beneficiary.

2. **Detach the Beneficiary Statement* and give to each beneficiary. Ask each beneficiary to complete it and return to you.**

   If there are multiple beneficiaries, each beneficiary should complete this form. It is only necessary for you to submit one Group Contract Holder Statement, regardless of the number of Beneficiary Statements completed. If you have difficulty obtaining forms from all beneficiaries, please submit the information you do have.

   *If the beneficiary is an estate, a minor, or not competent to handle financial affairs, the Beneficiary Statement should be completed by the appropriate legal representative (executor, administrator or guardian). If no legal representative has been or will be court appointed, this section should be completed by the person who assumed the responsibility for the estate or beneficiary.

3. **Documents to submit to Group Marketing Services**

   Submit the Group Contract Holder Statement, Beneficiary Statement and the following attachments:

   (1) A certified copy of the Death Certificate.

   (2) Legal documentation of the beneficiary, of the following situations:

   If the beneficiary is

   (a) an estate, a minor, or not competent to handle financial affairs: attach a certified copy of the court order appointing the legal representative.

   (b) A trust: include a letter verifying that the trust is still in effect. If the trust is testamentary, attach a certified copy of the will and a certified copy of the letters of Testamentary.

   (c) No longer living: include a certified copy of his/her death certificate.

   (3) If an Accidental Death claim is being filed, attach supporting information, such as a police report or newspaper clippings.

4. **Return both the Group Contract Holder Statement and the Beneficiary Statement with the required documents indicated above to:**

   Group Marketing Services, Inc.
   Claims Department
   PO Box 19040
   Kalamazoo, MI 49019-0040

If you have any questions please call our group claim division at (269) 343-2611 and a claim representative will assist you.

Great Lakes Employers Association

Group Marketing Services, Inc.
Group Insurance That Benefits Small Business

Group Life Insurance Claim Form
Employer Statement

Please send completed form and all attachments to:
P.O. Box 19040
Kalamazoo, MI 49019-0040

To avoid unnecessary delays, be sure all parts of the Claim Form are completed accordingly.

TO BE COMPLETED BY EMPLOYER/GROUP ADMINISTRATOR

Section 1: Employee Information

1. Employee Social Security Number	2. Name of Employee (Last, First M.I.)			3. Gender ☐Male ☐Female
4. Date of Birth	5. Date of Hire	6. Last Day Worked	7. Occupation	8. Phone Number

9. If not actively at work immediately prior to death, what was the reason? ☐Disability ☐Leave of Absence ☐Resigned ☐Discharged ☐Vacation ☐Temporary Layoff ☐Retired ☐Other:_____

10. Employee Address – Street | Apt No. | City | State | Zip

11. Work Classification ☐Hourly ☐Salary ☐Commission Only	12. Was coverage effective on date of death? ☐No, Explain why coverage terminated: ☐Yes

Section 2: Employer Information

13. Employer Name	14. Group Policy Number	15. Phone Number

16. Employer Address – Street | City | State | Zip

17. Location name and address where employed
Location Name | Street | City | State | Zip

Section 3: Deceased Information

(3A) Complete if the deceased was the EMPLOYEE

18. Date of Death		20. Salary on last date worked $ per ☐Hour ☐Week ☐Month ☐Year

21. Marital Status ☐Single ☐Married ☐Divorced ☐Legally Separated	22. Disabled? ☐Yes ☐No	23. Occupational Death? ☐Yes ☐No	24. Insurance Classification

25. Cause of Death	26. Are Accidental Death Benefits Being Claimed? ☐No ☐Yes, Explain Accident:

(3B) Complete if the deceased was a DEPENDENT

27. Deceased Social Security No.	28. Deceased Name (Last, First M.I.)		29. Deceased Gender ☐Male ☐Female
30. Deceased Relationship to Employee ☐Spouse ☐Son ☐Daughter ☐Other:_____	31. Date of Birth	32. Date of Death	33. Disabled? ☐Yes ☐No

34. Occupational Death ☐Yes ☐No	35. Effective date of dependent coverage	36. Cause of Death

37. Dependent's Marital Status ☐Single ☐Married ☐Divorced ☐Legally Separated	38. Was Dependent Employed? ☐Yes ☐No Name of Employer:

39. If dependent was 19 or over, was the dependent a full-time student? ☐Yes ☐No

Section 4: Employer Signature

40. Completed by (name of representative of the employer)

Print Name:_____ Signature:_____ Date:_____

Assurity Life Insurance Company
P.O. Box 19040 ▪ Kalamazoo, MI 49019-0040 ▪ Phone: 269-343-2611 ▪ Fax: 269-349-3275 ▪ www.groupmarketingservices.com

Group Life Insurance Claim Form – Beneficiary Statement

To avoid unnecessary delays, be sure all parts of the Claim Form are completed accordingly.

TO BE COMPLETED BY BENEFICIARY

Section A: Deceased Information

1. Deceased Social Security Number	2. Deceased's Name (Last, First M.I.)

Section B: Information about you, the Beneficiary

3. Beneficiary Name (Last, First M.I.)				4. Relationship to Employee	5. Date of Birth
6. Beneficiary social security number	7. Is beneficiary a legal U.S. citizen? ☐Yes ☐No				
8. Was insured legally married at their time of death? ☐Yes ☐No	If "Yes", were you the current spouse? ☐Yes ☐No	If "No", name of spouse:_____			
9. Beneficiary address – street	city	state	zip	10. Phone number	
11. If beneficiary is a minor, name of beneficiary's legal guardian (First M.I. Last)				12. Relationship to beneficiary	

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 may be guilty of a criminal act punishable under law. I hereby agree to reimburse Assurity Life Insurance Company (Assurity) to the extent of any overpayment which is In excess of the amounts payable under any Assurity insurance policy(ies). I hereby certify the statements above are complete and accurate to the best of my knowledge.

Beneficiary's signature:_____ Date: _____

AUTHORIZATION

I, on behalf of the person named above ("Insured"), authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau ("MIB"), consumer reporting agency, employer, Social Security Administration, Internal Revenue Service, Veterans Administration or other organization or person that has any records or knowledge of me or my health to disclose to Assurity Life Insurance Company ("Company"); its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from MIB):

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (except as maybe related directly or indirectly to sexual orientation), occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of Human Immuno deficiency Virus (HIV) infection and sexually transmitted diseases.
- Information on the diagnosis & treatment of mental illness & the use of alcohol, drugs, and tobacco, excluding psychotherapy notes.

I understand this information maybe released by the Company and/or its reinsurers to their consulting physicians, attorneys, MIB, and to other insurance companies in which the Claimant has policies or to whom claims for benefits have been made or maybe submitted.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Claimant do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, or other health care provider to release and disclose the Claimant's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for benefits under a policy. I understand that when information is used or disclosed pursuant to this authorization, it maybe subject to re-disclosure and may no longer be protected by the federal rules governing privacy of health information.

This authorization is valid for twelve (12) months from the date of signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time by providing written notice to the Company. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I understand that I may refuse to sign this authorization and that such refusal to sign will not affect the ability of the Claimant to obtain treatment. I further understand that if I refuse to sign this authorization, Company may not be able to make any benefit payments.

I understand that I will receive a copy of this authorization upon request and that a photographic copy of this authorization shall be as valid as the original.

_____ _____

Signature of Insured Legal Representative Date

Description of Personal Representative's Authority or Relationship to Insured:_____