United HealthCare Insurance Company

UnitedHealthcare Specialty Benefits
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Portland, ME 04112-7149
1-888-299-2070
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UnitedHealthcare®
A UnitedHealth Group Company

REQUEST FOR GROUP LIFE INSURANCE BENEFITS

(PROOF OF DEATH FOR GROUP INSURANCE)

INSTRUCTIONS:

1. Claimant please fill in and sign section below.
2. Certified Death Certificate must be included in proofs.
3. Attach copy of police report.
4. Attach copy of toxicology report and autopsy report.
5. Submit this form to Employer for completion of Section 2.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a notice of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

SECTION 1

CLAIMANT'S SIGNATURE

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		

SIGNATURE AND SOCIAL SECURITY VERIFICATION Please review the following statement and sign your name the way you would ordinarily sign a check. We are requesting your signature for two purposes: first, to certify your Social Security number; and second, to confirm your signature for the bank that will clear your checks.

Under the penalties of perjury, I certify that (1) the number I have documented on this form is my correct taxpayer identification number, and (2) 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 or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.

Social Security Number or Taxpayer Identification Number

Signature Date
(IMPORTANT: Sign your name the way you would ordinarily sign a check)

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that by furnishing the form and investigating the claim, the United HealthCare 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 hereby authorize United HealthCare Insurance Company to obtain any medical or hospital records on the deceased. A photostat of this authorization will be as valid as the original authorization.

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SECTION 2

STATEMENT OF EMPLOYER

We certify that, to the best of our knowledge and belief, the following statements and answers are true:

Full Name of Employee

Address of Employee	Street Address		
	City	State	Zip

Employer	Group Policy Number

Employee Social Security Number

__ __ __ - __ __ - __ __ __ __

Date to which Employee's Individual Premiums are paid

Date of Employment

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 Dependent Life Insurance $_____

Amount of Accidental Death and Dismemberment Insurance $_____

Name of Beneficiary *	Relationship

***Please attach any enrollment forms and beneficiary designations you retained.**

Provide Proof of Annual Earning if life insurance benefit is based on Annual Earnings.

Instructions: After completion of both sections of this form, PLEASE MAIL OR FAX to address/fax number shown on 1st section of this form. Be sure to include all supporting documents.

AUTHORIZED OFFICIAL MUST SIGN BELOW:

Name of Employer

Address of Employer

Telephone Number of Employer (with area code)

Signature of Employer

Printed Name of Signing Company Official

(**Signature Card Attached)**

OptumHealthBank℠

Wealth Management Account℠ Signature Card

IMPORTANT NOTE: If the amount of your payable proceeds is $5,000 or more, by signing this card a Wealth Management Account will automatically be established. Please complete all information below. OptumHealth Bank is unable to release account funds without this form on file.

Personal Information – Account Holder *(Please Print)*

Name: _____

Street Address
(Cannot be a PO Box): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Date of Birth: Social Security Number:

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.

Required Signature (Please Read Before Signing)

By signing below, I acknowledge that:

- I wish to establish an individual deposit account ("Account") relationship with OptumHealth Bank, Inc.
- I understand and agree that my Account will be established and governed by the OptumHealth Bank Account Terms and Conditions given to me and I acknowledge that the Account Terms and Conditions as well as OptumHealth Bank's Privacy Policy and Schedule of Fees will be binding on me. Furthermore, I understand and agree that OptumHealth Bank may change the Account Terms and Conditions, Privacy Policy and Schedule of Fees at any time and that I will be informed of any changes that affect my rights and obligations.
- I understand that I will be issued a Wealth Management Account MasterCard® Prepaid Debit Card ("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 certify that: (i) I am a U.S. citizen; (ii) the information provided in this signature card is true and complete, including but not limited to, the taxpayer identification number herein above; and (iii) 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.

X _____ _____

Signature of Account Holder Date