



LIFE INSURANCE CLAIM REQUIREMENTS

- 1) Completed claim form.
- 2) Notarized copy of the Death Certificate.
- 3) Copy of the Individual Application/Beneficiary Designation Form.
- 4) Copy of the previous year W-2 form.
- 5) If due to an injury or accident (MVA, Suicide, etc.):
 - a. Copy of Police Report.
 - b. Copy of Autopsy including Toxicology results.
 - c. Any newspaper articles or obituary.
- 6) Medical records may be requested if death occurred within 2 years of the effective date.

MAIL TO: TruAssure Insurance Company
801 Ogden Avenue
Lisle, IL 60532
Attn: Life Department

- Life Claim (Parts A-C,E)
- AD&D Claim (Parts A-C,E)
- Supplemental Life Claim (Parts A-C,E)
- Living/Accelerated Benefit Claim (Parts A,D,E)



A. To be completed by employer					GENERAL INFORMATION					
Name of Insured Group			Address of Insured Group							
Telephone No.			City				State		Zip	
Group Policy Number		Certificate No.		Effective Date of Insurance		Date Premium paid for Insured		Amount of Insurance		
Full Name of Insured Employee			Address of Insured Employee			Annual Salary of Employee		Employee Social Security No.		
Full name of Deceased/ Patient			Address of Deceased/ Patient			Relationship to Employee		Deceased/Patient on Premium Waiver?		
B. To be completed by employer					CIRCUMSTANCES OF DEATH					
Date of death		Place (if hospital or institution, give name)			Date sickness commenced		Date physician first consulted for last sickness			
Was Deceased considered an active eligible employee/dependent at time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Date employee last worked		Reason for stopping work								
Date completed		Signature of employer's authorized representative					Title (officer of the company)			
C. To be completed by the insured/family					IF DUE TO ACCIDENT					
Attach a copy of the accident report, medical examiners report or coroners report										
Date of accident		Was accident on the job or arise out of or in the course of deceased's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Describe how, where, and when fatal injury occurred and nature of injuries sustained										
BENEFICIARY INFORMATION										
(If additional space is needed, attach separate paper)										
Name of beneficiary			Social Security Number		Relationship			Date of Birth		
Address				City			State		Zip	
Name of beneficiary			Social Security Number		Relationship			Date of Birth		
Address				City			State		Zip	
Name of beneficiary			Social Security Number		Relationship			Date of Birth		
Address				City			State		Zip	

D. ATTENDING PHYSICIAN'S STATEMENT

Name of Patient		Date of birth	
When did symptoms first appear or accident happen?	Date patient ceased work because of disability?	Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state when and describe	
Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Names and addresses of other treating physicians		
Diagnosis (including complications)	Subjective symptoms		
Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings)			
Date of first visit	Date of last visit	Frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify)	
Nature of treatment (including surgery and medications prescribed, if any)			
Has patient <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Retrogressed	Is patient <input type="checkbox"/> Ambulatory <input type="checkbox"/> House confined <input type="checkbox"/> Bed confined <input type="checkbox"/> Hospital confined <input type="checkbox"/> Hospice care		
Has patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give name and address of hospital Confined from _____ through _____		
Please indicate patient's long term and short term prognosis (including life expectancy)		Indicate duration of illness (from initial onset to present)	
Name (attending physician) print	Degree	Telephone	
Street address	City or town	State or province	Zip code
Signature			Date

E. To be completed by the insured/family**AUTHORIZATION TO DISCLOSE HEALTH-RELATED INFORMATION****(This Authorization complies with the HIPAA Privacy Rule)**

I AUTHORIZE any physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility or provider, clearinghouse, health plan, insurance or reinsuring company, agent, broker, service provider, credit bureau or other consumer reporting agency, employer, the Veterans Administration, the Medical Information Bureau, Inc., or any other personal or business associate to disclose any and all "Information" about the claimant to TruAssure Insurance Company, its employees, agents or representatives (TruAssure). "Information" may include the claimant's entire medical record, diagnosis, prognosis, prescription history, medicines prescribed, treatment or care of any physical or mental condition concerning the claimant, including information about HIV/AIDS, drug or alcohol abuse or mental illness (excluding psychotherapy notes), and/or financial, consumer report or any other medical or non-medical information about the claimant.

The information to be disclosed under this Authorization may be used by TruAssure to: 1) underwrite the application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities relating to any coverage approved or applied for with TruAssure.

I understand that I have the right to revoke this Authorization at any time by providing written notice of revocation to TruAssure. I am aware that my revocation will not be effective until received by TruAssure and will not be effective regarding the uses and/or disclosures of the claimant's Information that TruAssure has made prior to receipt of my revocation. If the authorization was obtained as a condition of obtaining insurance coverage, other law provides TruAssure with the right to contest a claim under the policy or the policy itself. A copy of this form shall be as valid as the original.

AUTHORIZATION TO DISCLOSE HEALTH-RELATED INFORMATION (CON'T)

I understand that I am under no obligation to sign this Authorization but that my refusal to sign it may prevent TruAssure from being able to process the claimant's application for coverage, determine the claimant's eligibility or make benefit payments. The claimant's physician or other health care provider may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that once Information is disclosed under this Authorization, it may no longer be protected by federal privacy rules and may be re-disclosed by the person or entity that receives it. I am entitled to keep a copy of this form for my records. This Authorization shall expire 30 months from the date signed.

I CERTIFY that the statements on this claim form are true, complete and correct to the best of my knowledge and belief.

Signature of Insured or legal representative

Date

Signature of irrevocable beneficiary (power of attorney)

Date

MAIL TO: TruAssure Insurance Company, 801 Ogden Avenue, Lisle, IL 60532 - Attn: Life Department

For Life Benefits – A NOTARIZED COPY OF THE DEATH CERTIFICATE MUST ACCOMPANY THIS FORM