



Underwritten by Trustmark Insurance Company

Death Benefit Claim

For Claims Customer Service:

Phone: (800) 225-3859

For Claims Submission:

Fax: (508) 853-0310

Email: Claims@ULAflac.com

Mail: Attn: Life Claims PO Box 60676, Worcester, MA 01606

Instructions

- The **Statement of Physician** section must be completed by the deceased's primary care physician, **ONLY** if the death occurred within the first two (2) years from the effective date of the policy.
- A **Beneficiary's Statement** must be completed by the person to who the insurance is payable. In connection with such statement, the following should be observed:
 - If there is **more than one beneficiary**, all may join in one statement or a separate form will be furnished for each if desired.
 - If the policy is **payable to the estate or to the executors or administrators of the insured**, the statement should be completed by the executor or administrator, a certificate of whose appointment and qualifications must be furnished.
 - If the policy is **payable to a minor or a mentally incompetent person**, the statement should be completed by a guardian, a certificate of whose appointment and qualifications must be furnished.
 - If the policy has been **assigned**, special instructions will be furnished.
- A **Certified Copy of the Death Certificate** must be furnished for **insured**.
- A **Certified Copy of the Death Certificate** for any **deceased beneficiary** must be furnished.
- If the cause of death is due to an injury or accident, please enclose a photocopy of the police report and/or newspaper articles concerning the circumstances.

Section A – Beneficiary's Statement

Policy / Certificate #: _____

Deceased's Full Name: _____

Deceased's DOB: ____/____/____

Residence Address: _____
Street City State Zip Code

Date of death? ____/____/____ Place of death: _____

Cause of death: _____

Insured was totally disabled prior to Death? Yes No As of what Date? ____/____/____

When did deceased first complain of or give other indications of the last illness? ____/____/____

When did deceased first consult a physician for the last illness? ____/____/____

Names & addresses of all physicians or practitioners who attended or prescribed for deceased within the five years preceding death			
Physician Name	Address	Phone/Fax #'s	Disease or Condition

Has deceased at any time been confined to a hospital? Yes No If yes, when? ____/____/____

If yes, where? _____

If optional settlement is available, and you do not desire payment in one sum, state type of settlement desired: _____

***** Complete & Sign Disclosure Authorization Portion of Claim Form *****



Underwritten by Trustmark Insurance Company

Death Benefit Claim

For Claims Customer Service:

Phone: (800) 225-3859

For Claims Submission:

Fax: (508) 853-0310

Email: Claims@ULAflac.com

Mail: Attn: Life Claims PO Box 60676, Worcester, MA 01606

Section B – Attending Physician’s Statement *(To be completed by the Attending Physician)*

Deceased’s Full Name: _____ Age At Death: _____

Residence at death: _____ Occupation: _____

How long have you known the deceased? _____

Date & Time of death? ___/___/___ Place of death: _____

If death occurred in hospital, please give name & address: _____

When you were first consulted for the condition which directly or indirectly caused death: ___/___/___

What was the immediate cause of death? _____

How long, in your opinion, did this disease or impairment exist? _____

What was the date of onset of the first symptom or sign according to the clinical history? ___/___/___

Contributory cause of death: _____ Duration: _____

Other chronic diseases or impairments: _____ Duration: _____

Please give particulars of each condition for which you treated or advised deceased prior to last illness			
Disease or Condition	Date	Duration	Result

Please give name & addresses of all other physicians or other practitioners who attended deceased within the five years preceding death			
Physician Name	Address	Phone	Disease or Condition

Physician’s name (please print) _____ Specialty _____

Phone: ___-___-___ Fax: ___-___-___

Address: _____
Street City State Zip Code

Signature _____ Date ___/___/___

For Claims Customer Service:

Phone: (800) 225-3859

For Claims Submission:

Fax: (508) 853-0310**Email:** Claims@ULAflac.com**Mail:** Attn: Life Claims

PO Box 60676, Worcester, MA 01606

State Required Fraud Warnings

Fraud Statement for Alaska and New Hampshire Residents: 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.

Fraud Statement for AZ Residents: 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.

Fraud Statement for CA Residents: For your protection, California law requires the following to appear: **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.**

Fraud Statement for CO Residents: 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.

Fraud Statement for FL Residents: 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.

Fraud Statement for Kansas, and Oregon Residents: Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which may be a crime.

Fraud Statement for KY Residents: A person who knowingly and with intent to defraud any insurance company or other person files a 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.

Fraud Statement for Arkansas, Louisiana, New Mexico, Texas, and West Virginia Residents: 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.

Fraud Statement for Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Statement for MN Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

FRAUD STATEMENT FOR PENNSYLVANIA RESIDENTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES ANY 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.

Fraud Statement for New Jersey: ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Fraud Statement for Ohio Residents: 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.

FRAUD STATEMENT FOR DISTRICT OF COLUMBIA, MAINE, TENNESSEE, VIRGINIA AND WASHINGTON RESIDENTS: 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.

Fraud Warning for Delaware, Idaho, Indiana, and Oklahoma, As Well as for the Residents of All States Not Specifically Listed WARNING: Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which is a felony.



Underwritten by Trustmark Insurance Company

Death Benefit Claim

For Claims Customer Service:

Phone: (800) 225-3859

For Claims Submission:

Fax: (508) 853-0310

Email: Claims@ULAflac.com

Mail: Attn: Life Claims PO Box 60676, Worcester, MA 01606

DISCLOSURE AUTHORIZATION

Insured's Name (Please Print): _____

I AUTHORIZE any doctor, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, consumer reporting agency, insurance support organization, insurance agent, employer, financial institution, the Social Security Administration, the Internal Revenue Service, the Veterans Administration or any other organization or person having any knowledge of the insured or his or her health to give to Trustmark Insurance Company and affiliates or its employee and agents, or any other consumer reporting agency any information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to the physical or mental condition or information concerning the insured, his/her occupation, employment history, earnings or finances or information otherwise needed to determine policy claim benefits due me. This may include, but is not limited to, HIV Infection, any disorder of the immune system including Acquired Immune Deficiency Syndrome (AIDS), driving records, mental illness, or use of alcohol or drugs.

I further AUTHORIZE the Social Security Adm. to release information or records about the insured to Trustmark Insurance Company or authorized representatives. This information is to be released in order to properly adjudicate my claim for benefits. Please release detailed earnings for up to the last ten years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits.

This authorization may be revoked by me. Any such revocation must be in writing, must be signed and dated by me and must be forwarded directly to the Trustmark Insurance Company. I AGREE the information obtained with this Authorization may be used by Trustmark Insurance Company and affiliates to determine policy claim benefits with respect to the Insured. A photocopy of this authorization is as valid as the original and I may request a copy. This authorization will be in force for the duration of the claim. I understand that if I revoke or fail to sign this authorization or alter its content it may affect the handling of my claim including denial of benefits under my policy.

I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I AUTHORIZE Trustmark Insurance Company and affiliates to report to ICS, any dates of past or present claims filed by me.

Residents of MT – You are entitled to request a record of any subsequent disclosure of information.

RESIDENTS OF NM – Revocation of the authorization must be made within 10 days after its receipt by Trustmark Insurance Company; this applies only to confidential abuse information.

Residents of Florida – Any person who knowing and with intent to injure, defraud or deceive any insurance company files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Residents of NY – 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim or each such violation.

Signature: _____ Date Signed: ___/___/___

Printed Name: _____ Date of Birth: ___/___/___ SSN: _____

Relationship: _____ Daytime Phone Number (____) _____ - _____

Residence Address: _____

Street City State Zip Code

Signature: _____ Date Signed: ___/___/___

Printed Name: _____ Date of Birth: ___/___/___ SSN: _____

Relationship: _____ Daytime Phone Number (____) _____ - _____

Residence Address: _____

Street City State Zip Code



Underwritten by Trustmark Insurance Company

Death Benefit Claim

For Claims Customer Service:

Phone: (800) 225-3859

For Claims Submission:

Fax: (508) 853-0310

Email: Claims@ULAflac.com

Mail: Attn: Life Claims PO Box 60676, Worcester, MA 01606

Beneficiary Statement of Claim – Communication

CONSENT FOR USE OF ELECTRONIC COMMUNICATIONS (EMAIL, SMS/MMS TEXT MESSAGING)

To ensure the best and fastest communication, we would like to communicate with you using either email or text messaging. Please complete this section if we can communicate with you electronically, concerning your claim, benefits, policy, premium or condition.

May we communicate with you electronically?

No

Yes, by Text Messages - Please provide cell phone #: (____) - ____ - ____

Yes, by Email Please provide email address: _____@_____

If you chose to communicate with us electronically, you should be aware that electronic communication is not secure unless it is encrypted. We strongly encourage you to use encrypted communication when sending sensitive and/or confidential information. By sending sensitive or confidential electronic messages that are not encrypted, you accept the risks of such lack of security and possible lack of confidentiality. If you elect to communicate from your workplace computer, you should also be aware that your employer and its agents, have access to electronic communication between you and us.

I understand that by selecting text messaging, regular text messaging rates may apply for any texts I receive from Trustmark and I assume responsibility for any costs associated with these text messages. This consent shall remain in effect unless revoked in writing.

To ensure a smooth email experience, please be sure that your computer has the most up to date version of Adobe Reader. You should add our email address to your address book contact list and add us to your email server or spam filter approved listing. If you don't see email from us in your email inbox, be sure to check your spam, clutter, junk or bulk email folder. You can choose to stop electronic communication at any time by revoking this authorization. If you no longer wish to communicate via electronic means we will correspond with you via US mail. If you require copies of any communication sent to you by email/text in paper form, please contact us. There is no cost to you to obtain copies of electronic communication in paper format.

Authorization

I may revoke or update this authorization in writing at any time or by email to Claims@ULAflac.com.

Trustmark Insurance may rely on the information I provide for the adjudication of my claim as a result of this authorization until receipt of my revocation notice. This authorization is valid for two (2) years. I may request a copy of this authorization and a copy is as valid as the original.

Policy Owner or Beneficiary Signature

Date

Printed Name

Social Security Number