AMERICAN FIDELITY
a different opinion

Life Benefits Department | P.O. Box 25160 | Oklahoma City, OK 73125-0160
American Fidelity Assurance Company | 800-662-1113 | Fax: 800-818-3453 | **afa-life-claims@americanfidelity.com** | **americanfidelity.com**

DEATH BENEFIT CLAIM FILING INSTRUCTIONS

To help avoid delay, please read these instructions carefully and complete statement of claimant and Internal Revenue Service Form W-9.

- Submit a **CERTIFIED** Death Certificate of the deceased insured showing the Cause and Manner of Death.
- Submit a completed Internal Revenue Service (IRS) Form W-9 Form for each payee (beneficiary, assignee, trustee, administrator of estate, guardian of a minor, heir).
- Submit a copy of the **CERTIFIED** Death Certificate of each deceased beneficiary.
- Submit a completed **Statement of Claimant** form. Each beneficiary must complete and sign a Statement of Claimant form.

Claims by an Estate — The Executor (Administrator or Personal Representative) of the Estate must sign all documents including the Statement of Claimant and IRS Form W-9 on behalf of the Estate. A certified copy of the appointment papers should be included. A Last Will and Testament cannot be accepted as proof of authority of executorship.

Assignments — If all or any portion of the benefits have been assigned to a funeral home or any other entity, please include a copy of that assignment signed by each beneficiary. The signature(s) must be notarized for the assignment to be accepted. The assignee must complete an IRS Form W-9.

If the beneficiary is a minor — A legal guardian must be appointed by a court giving custody over the minor's property and estate. The legal guardian should sign the Statement of Claimant and IRS Form W-9 and include a copy of the court-appointed guardianship papers.

If the beneficiary is a trust — The trustee must sign the Statement of Claimant and complete the IRS Form W-9 on behalf of the trust. A copy of the trust certificate or memorandum of trust should be included.

If any beneficiary has a designated attorney-in-fact — The attorney(s)-in-fact should sign on behalf of the beneficiary and include a copy of the Power of Attorney appointment.

If the policy is less than two years of effective date or reinstatement date — As part of our normal process, additional information and documentation will be required with the claim. An AUTHORIZATION TO USE OR DISCLOSE PROTECTED INFORMATION form must be completed and submitted with the claim.

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STATEMENT OF CLAIMANT

To be completed for Life Insurance benefits.
In furnishing this form, the Company reserves all rights under the Policy and waives none of the conditions of the Policy.

INSURED/CLIENT IDENTIFICATION

Full Name: (last, first, middle initial)	
Date of Birth: / /	Date of Death: / /
Cause of Death:	
Social Security Number: - -	Policy Number:
Last Known Address (P.O. box or street, city, state & zip):	

CLAIMANT'S IDENTIFICATION

Full Name: (last, first, middle initial):	
Relationship to Deceased:	
Social Security Number: - -	Date of Birth: / /
Telephone Number:	Email address:
Address (P.O. box or street, city, state & zip):	
Do you claim this insurance as: ❒ Beneficiary/Heir ❒ Executor/Administrator ❒ Trustee ❒ Guardian ❒ Power of Attorney	

ACCIDENTS **(Complete only if loss is the result of accidental injury)**

Date of Accident: / /
Where did the accident happen?:
How did the accident happen?:

If the policy contains an accidental death benefit and claim is being made for it, please furnish a detailed police report, coroner's report, toxicology report and newspaper clippings (if applicable). We may require other information depending on the circumstances of the death.

CERTIFICATION
I certify the above statements are true and complete to the best of my knowledge.

Warning: 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 may be guilty of insurance fraud and subject to criminal and civil penalties. Refer to "Claim Form Fraud Statements" for your state.

Claimant/Beneficiary Signature: _____

Date:_____

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Authorization to Obtain Information Including Protected Health Information

The purpose of this form is to allow American Fidelity Assurance Company, or business partners acting on behalf of American Fidelity in the administration of American Fidelity products and services to obtain data including but not limited to employment information, financial information, and protected health information about the deceased, from any party holding that information. Once obtained, American Fidelity may use this data to review or process benefits, confirm policy information, or otherwise review or process information related to the deceased's relationship with them.

I hereby authorize the entities specified below to disclose any information about the deceased's health or financial situation, including the deceased's entire medical record and history of treatment for physical and/or emotional illness, including psychological testing, except psychotherapy notes, to individuals representing American Fidelity who are involved in determining whether the deceased is eligible for benefits under the deceased's insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics, or medically-related facilities or their business associates; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, k) banks or financial institutions and l) Workers' Compensation Carrier. American Fidelity will only disclose any data collected pursuant to this authorization as necessary for our legitimate business purposes and only to the extent allowed by law.

Notice: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome), or other conditions for which the deceased may have been treated.

I understand that American Fidelity may not condition payment of claims, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign may result in a denial or an inability to pay benefits under the policy if my failure to sign results in American Fidelity not having enough information to process benefits. I understand that I may revoke this authorization at any time by writing to American Fidelity, P.O. Box 268923, Oklahoma City, OK 73126-8923 or by calling, toll-free, 800-735-9701. I understand that my right to revoke this authorization is limited to the extent that: American Fidelity has taken action in reliance on the authorization; or the law provides American Fidelity with the right to contest the deceased's insurance coverage or a claim under the deceased's insurance coverage. A copy of this authorization will be as valid as the original.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by federal privacy regulations. In addition to the types of information described above, I also authorize American Fidelity to access any other type of information deemed necessary to investigate the claim. This information includes but is not limited to financial information, information submitted or related to insurance claim(s) or insurance coverage(s) and employment records. Any party holding this information is hereby authorized to release it to American Fidelity.

For health insurance coverage, this authorization will expire twenty-four months from the date it is signed or upon the termination of the insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of the claim for benefits, whichever occurs first.

Customer # | Printed Name of Deceased | Deceased's Date of Birth

Signature of Beneficiary/ Personal Representative | Date Signed

Relationship of Personal Representative to Deceased (if applicable)

If authorization is supplied by a personal representative, a description of the authority to act on behalf of the insured must be included.

Please retain a copy for your personal records, or you may request a copy from our company.

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Claim Form Fraud Statements

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

If you live in a jurisdiction not mentioned below, the following applies to you: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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, District of Columbia, Louisiana, Rhode Island and West Virginia - 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.

For your protection **California** law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confiment 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, Idaho and 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.

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.

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 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.

Maine, 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 may include imprisonment, fines and/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 for 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 AN 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.

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.

For your protection **Texas** law requires the following to appear on this form: Any person who knowingly presents 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.