CONSUMERS LIFE®
A MEDICAL MUTUAL COMPANY

15885 W. Sprague Road, Strongsville, Ohio 44136-1772

Death Claim Form

Telephone: 866-925-2542
Fax: 440-878-6916
Email Address: Claims@ConsumersLife.com

Required Documents for the submission of a Death Claim – Group Life Insurance

To ensure prompt handling of this claim, please return the fully completed death claim form along with the following documents:

- Certified Death Certificate
- A copy of the original Employee Enrollment Form
- Most recent Beneficiary Designation Change Form
- If Accidental Death Benefits are being claimed:
  - If due to a motor vehicle accident or crime, please include a copy of the Police Report.
  - For other accidents, please include supporting documentation (newspaper clippings, witness statements, Employer OSHA accident report, etc.)

If the death claim is faxed or emailed to our office for processing, please note that the original Certified Death Certificate must also be mailed.

STATEMENT OF EMPLOYER/GROUP

Group Number

Employee Information

Name	Address	Social Security No.	Date of Birth
			/ /

Job Title/Occupation	Date Employed	Date Last Worked	Base Annual Salary On Date Last Worked	Date of Death
	/ /	/ /	$	/ /

If not actively at work immediately prior to death, what was the reason?

☐ Disability/Illness ☐ Resignation ☐ Retirement ☐ Layoff
☐ Leave of Absence ☐ Vacation ☐ Other (explain briefly): ________________

Type/Amount of Insurance Being Claimed:

☐ Basic Life $________ ☐ Supplemental Life $________ ☐ Voluntary Life $________
☐ Basic AD&D $________ ☐ Supplemental AD&D $________ ☐ Voluntary AD&D $________
☐ Dependent $________ Name and relationship to employee ________________
☐ Other (please specify type of coverage)________________ $________

Are premiums paid to date for this insured? ☐ Yes ☐ No	Date insurance coverage was discontinued, if not in force: / /	Was a Disability or Waiver of Premium claim submitted for this employee prior to the date of death? ☐ Yes ☐ No If yes, the type of claim and name of insurance carrier: ________________

Beneficiary Information (if more than 1, please attach a separate sheet with this information for each beneficiary)

Name	Address	Social Security No.	Date of Birth*
			/ /

*If beneficiary is a minor, please include the name/address of the minor's guardian.
Note: If any beneficiary entitled to benefits is deceased, please submit a copy of his/her death certificate.

EMPLOYER/GROUP CERTIFICATION: ***I hereby certify that the information provided is true and complete according to the records of the Employer/Group. I agree that this information is subject to review by Consumers Life Insurance Company and/or its representatives.***

________________ ________________ ________________
Authorized Representative (please print) Authorized Representative Signature Date

________________ ( ) ________________ ( ) ________________
Group Name Telephone Number Fax Number

________________ ________________
Group Mailing Address Group Email Address

NOTE: 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 act, which is a crime and subjects such person to criminal and civil penalties. (Not enforceable in Oregon and Virginia.)

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Fraud Notices

The laws of some states require us to furnish you with the following notice:

For residents of all states except California, Florida, New Jersey, New York, Pennsylvania, Utah, Vermont, Virginia and Washington; WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

CALIFORNIA RESIDENTS – For your protection, California law requires the following to appear on this form. 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.

FLORIDA RESIDENTS – Any person knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW JERSEY RESIDENTS – Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS – 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 for each such violation.

PENNSYLVANIA and UTAH RESIDENTS – 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 materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

VIRGINIA RESIDENTS – Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

VERMONT RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

WASHINGTON RESIDENTS – Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.