Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (800) 775-8805
Fax (402) 997-1835
Email submitgrplife@mutualofomaha.com

Instructions for Filing a Proof of Death Claim Form

Upon the death of an insured employee, plan member or insured dependent, the employer/plan administrator must complete the claim form as indicated and send attachments mentioned below. Be advised that further documentation might be necessary in the future to complete the claim process.

Please submit the required documentation:

1. Proof of Death claim form:

   Part I – Completed by the employer/plan administrator
   Part II – Completed by the beneficiary(ies)

2. Beneficiary Designation form, including beneficiary changes.

3. Original, photocopies or screen-print of enrollment form.

4. Original certified death certificate showing cause and manner of death. If the benefit amount is $200,000 or less, a copy of the death certificate showing cause and manner of death is acceptable.

5. For accidental death benefits, provide the following items, including but not limited to:
   a. Official investigative report (police, accident, fire, FAA, OSHA)
   b. Proof of seatbelt/airbag use, if applicable
   c. Coroner's report or Medical Examiner's report findings and/or toxicology report

6. If the beneficiary is:
   a. An Estate – We require the Letters Testamentary or Letters of Administration appointing the personal representative of the estate.
   b. A Trust – We require a copy of the following pages of the Trust – Face page of Trust, Trustee or Successor Trustee designation and Signature page of Trust.
   c. A Minor – According to state law, a minor lacks capacity to sign a binding release of an insurance contract.

      For this reason, life insurance benefits are not directly payable to a minor beneficiary. The following are options available when the beneficiary is a minor:

      1. UTMA (Uniform Transfer to Minors Act) – UTMA payment may be utilized providing that the benefit amount including interest is under the amount allowed for the minor beneficiary's state of residence.
      2. Guardianship papers – The minor's custodian may obtain formal guardianship papers for the minor's estate. These legal guardianship documents must be obtained prior to the release of the benefit.

7. If the beneficiary has predeceased the insured and no contingent beneficiary is named or the insured did not name a beneficiary:
   a. Payment of the life insurance benefits will be paid in order as specified in the policy provisions of the contract.
   b. The surviving heir must complete an Affidavit of Preferential Beneficiary Designation Form, which must be notarized.

The Proof of Death claim form should be returned to:

United of Omaha Life Insurance Company
Group Life Claims
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
or
Fax (402) 997-1835
Email submitgrplife@mutualofomaha.com

Fraud Warnings

Required Fraud Warnings (State specific warnings apply to the resident of such state)

Fraud Warning: 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.

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.

Arkansas/Kentucky/Louisiana/Maine/New Mexico/ Ohio/Tennessee: Any person who, with intent to defraud or knowing that he/she 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.

California: 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 confinement 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.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kansas: 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 as determined by a court of law.

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.

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 York: 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.

Oregon: 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 may be a crime and may subject such person to criminal and civil penalties.

Puerto Rico: Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed 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.

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

Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Virgin Islands: 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 penalties.

Virginia: Any person who, with the 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 may have violated state law.

Proof of Death Claim Form

Part I – To Be Completed by the Employer or Plan Administrator

The deceased is insured as: ❑ Employee/Member ❑ Spouse ❑ Child

1. Name of Claimant/Deceased_____

   Name of Insured/Member (If not the deceased person) _____

2. Date of death _____ Date of birth_____ Age_____

3. Social Security Number of deceased_____

4. Employee's/Insured's marital status:
   ❑ Single ❑ Married ❑ Widow/Widower ❑ Separated ❑ Divorced ❑ Domestic Partner ❑ Civil Union

5. Amount of insurance for the deceased:

   Basic Life_____ Voluntary Life_____

   Basic AD&D _____ Voluntary AD&D_____

   Basic Dependent Life _____ Voluntary Dependent Life _____

   Voluntary Dependent AD&D _____

   If applicable attach enrollment record from when coverage was first elected (in written or electronic format).

6. Name of beneficiary as shown on your records _____ Relationship _____
   Attach a copy of the current beneficiary designation form (In written or electronic format).

7. Date on which the Employee was last present at work?_____

8. For Dependent Claims – Is the Employee still actively working? ❑ Yes ❑ No If **No**, give employees last date of active work _____

9. Reason for Employee/Insured ceased work:
   ❑ Illness (Including disability leave of absence/partial disability) ❑ Leave of absence (Other than disability)

   ❑ Quit ❑ Dismissed ❑ Vacation ❑ FMLA ❑ Retired (Date)_____ ❑ Layoff ❑ Deceased

10. Was the Employee disabled? ❑ Yes ❑ No

    If **Yes**, date disability began _____ Date partial disability began_____

11. Date premium for the above deceased has been paid through _____

12. Date of Hire_____ ❑ Full Time ❑ Part Time

    ❑ Union ❑ non-Union ❑ Hourly ❑ Exempt ❑ non-Exempt ❑ Salaried

    Annual Salary (If salary based) $_____ Date of last salary increase_____

    Average hours worked per week_____ Occupation_____ Class_____

13. Effective date of deceased's insurance with Mutual of Omaha or United of Omaha _____

We hereby certify that to the best of our knowledge and belief, the above statements are correct and that said deceased's insurance was in force on the date of his or her death.

Group Policy Number _____ Name of Policyholder_____

Printed name of authorized Employer/Plan Representative _____

Signature of authorized
Employer/Plan Representative _____ Date _____

Phone number _____ Email address_____

Part II – To Be Completed by Beneficiary*

**If there is more than one beneficiary, each must complete a separate form.*

Name _____
(First) (Middle initial) (Last)

Beneficiary's Social Security Number or Taxpayer Identification Number _____

Date of birth _____ Home phone _____ Cell phone _____

Address _____

City _____ State _____ ZIP Code _____

Email address _____

Name of deceased _____ Relationship to deceased _____

Group policy number of deceased _____

Cause and manner of death, if known _____

Was the death caused by an accident? ❑ Yes ❑ No
(If **Yes** and the policy includes an accidental death and dismemberment provision, we may require a copy of the Police/Accident Report, Autopsy/Medical Examiner's Report, Toxicology, and Death Certificate with cause and manner of death as accident.)

If you are not the named beneficiary, in what capacity do you make this claim? _____

Does the deceased have any other life insurance coverage with Mutual of Omaha or United of Omaha? ❑ Yes ❑ No

If the deceased was a dependent fill out the following:

Was the dependent disabled? ❑ Yes ❑ No If **Yes**, describe the disability _____

Date disability began _____ Dependent's last day worked _____

Dependent's employer _____ Dependent's employer's phone number _____

Is child: ❑ Full-time student ❑ Part-time student

Name & address of school _____
(Street) (City) (State) (ZIP code)

Certification

In order for us to comply with applicable IRS reporting requirements, please complete the following certification:

Under penalty of perjury, I certify that:

a) The statements I have made on this form, including my Taxpayer Identification Number (or the fact that I am waiting for a number to be issued to me), are correct, and
b) 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 and dividends, or the IRS has notified me that I am no longer subject to backup withholding.
c) I am a U.S. person.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

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.

Your signature _____ Date _____

Printed name _____

Authorization to Release Personal Information

1. I (the undersigned) authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records containing the Personal Information of:

   Name of Claimant _____
   (Last) (First) (Middle)

   Date of Birth_____/_____/_____ Social Security Number_____-_____-_____

   This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

2. **Personal Information to be released:**
   - data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), X-rays, films or correspondence, and any medical condition I may now have or have had;
   - any information regarding insurance or benefit plan coverage, claims or benefits; and/or
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)

3. **You may release my Personal Information to:**
   Group Life Claims
   United of Omaha Life Insurance Company
   3300 Mutual of Omaha Plaza
   Omaha, NE 68175-0001
   or Fax: 402-997-1835 or Email: submitgrplife@mutualofomaha.com

4. **I understand my Personal Information will be used by Mutual to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid. I also authorize Mutual to release my Personal Information as follows:**
   - to its reinsurer, or other persons or organizations performing business, legal or insurance support services in connection with my claim(s); or
   - to a vendor specializing in the application for Social Security Disability Benefits; or
   - to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
   - for self-insured disability plans only, to my employer; or
   - for fully insured plans to my employer for use in discussions with Mutual regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
   - as otherwise required or permitted by law or as I further authorize

5. I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

6. I understand that I may revoke this Authorization at any time by providing a written request to Mutual at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Mutual's receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 months after the date signed.

7. I understand that I am entitled to receive a copy of this Authorization and that a copy is as valid as the original.

RETAIN A SIGNED COPY FOR YOUR RECORDS

Name(s) used for records (if different than the name below): _____

_____

_____ _____
Signature of Claimant Date

If Applicable: I am the legal representative of the Claimant and I am authorized to grant permission on behalf of the Claimant.

Printed Name of Legal Representative _____

Signature of Legal Representative _____

Type of Legal Representative _____

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Electronic Funds Transfer (EFT) Authorization

Direct Deposit of Benefit Payments

I understand that by completing this form, I am authorizing United of Omaha Life Insurance Company to directly deposit into my bank account via Electronic Funds Transfer (EFT) payment(s) due to me under a contract issued by United of Omaha to my financial institution with the information provided below, for credit to my account. I represent that the bank information listed below is not affiliated with a prepaid banking card or a non-standard checking/savings account, and I understand that such prepaid banking card or non-standard checking/savings accounts are not accepted by United of Omaha.

Furthermore, I authorize and direct the bank to charge said account or the account of my estate for any payment made in error as determined by United of Omaha and to refund any such payment made subsequent to my death or made in error and to refund any such payment to United of Omaha upon its written request to the bank.

I further understand and agree that it is my responsibility to ensure that all bank information reported on this form is accurate and correct for the appropriate deposit of my payment(s) and that United of Omaha can rely on this information and will have no obligation to ensure the correctness of the information. Completion of this form is not a guarantee that benefits will be paid.

I further understand and agree that any payment(s) made into an incorrect bank account (including, without limitation, to a prepaid banking card or non-standard checking/savings account, both of which are not accepted by United of Omaha) pursuant to the information reported on this form, will be forfeited by me and that United of Omaha has no obligation to retrieve those funds or make replacement payment(s) to me.

I further understand and agree for myself, my heirs, executors and estate to indemnify and hold United of Omaha harmless from any and all loss or damage of any nature whatsoever, including costs or attorney's fees incurred by reason of said bank acting pursuant to this Authorization.

I further understand and agree that United of Omaha is not responsible for any bank charges or other costs associated with or arising out of this agreement.

I further understand that if my bank is not able to accept EFTs, checks will be mailed to my residence.

I reserve the right to revoke and cancel this authorization. Such revocation and cancellation shall be effective within 5 business days following United of Omaha's receipt of the notice.

Payee Information	**Bank Information**
Full Name	Bank Name
Address	Address
Address	Address
City	City
State and ZIP Code	State and ZIP Code
Telephone Number ( )	Telephone Number ( )
Social Security Number	Account Number
Policy Number	Bank ABA Routing/Transit Number
Claim Number	❑ Checking ❑ Savings *(Check only one)* *Prepaid banking cards and non-standard checking/savings accounts not permitted.*
Payee Number *(for office use only)*	**Approved By/Date *(for office use only)***

X _____ _____

Payee Signature Date

Contact Information

Please attach EITHER **a voided check for checking** OR **a deposit slip for savings** and return with this form to:

United of Omaha Life Insurance Company
HO8W-GDMS
3316 Farnam Street
Omaha, NE 68172-7420

You may also fax to 402-997-1835 or email to submitgrplife@mutualofomaha.com

Should you have any questions regarding EFT, please feel free to contact our customer service representatives toll free at **1-800-775-8805** (Monday – Thursday 7a.m. – 5:30p.m. and Friday 7a.m. – 5p.m. CST).

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Coping with Loss

Adjusting to losing a loved one

At times of grief and loss, it's not uncommon to be confused and uncertain about how to proceed.

We asked grief counselors, physicians and financial advisors what advice they would offer friends and clients during this difficult time. Some of their advice follows.

Grief & loss can affect your health

Be careful of your physical well-being, too. Your distress may manifest itself in sleeplessness and loss of appetite, adding to your emotional upset. The physical demands of added responsibilities may also take their toll. So, learn to ask for help and go easy on yourself.

Losing a loved one is one of life's most difficult trials

Each loss, like each relationship, is unique and each grief journey follows its own path and takes its own time. Strong emotions are natural and are a part of the healing process. Accepting those emotions and giving yourself permission to have them are important steps in the journey. Some mourners find solace in support groups or with professional counselors.

Finances

You may face major new financial responsibilities at this time. Not only must you put your own finances in order, but you may be called upon to make decisions regarding the estate of the deceased.

Do not give in to pressure to make snap decisions you might regret later. Protect yourself by consulting with the appropriate advisors, such as your accountant, attorney, insurance representative or financial planner.

Important Papers

If the deceased was your spouse, or you are executor of the estate, financial advisors suggest you search for important items and documents, including:

- Insurance policies
- Employee benefit plan documents
- Business agreements
- Wills/Trusts
- Income tax returns and W-2 forms
- Marriage and birth certificates

For Additional Assistance

For confidential assistance coping with grief and loss, reach a knowledgeable and understanding counselor, 24 hours a day, seven days a week at **1-800-316-2796.**

*Questions regarding your claim or claim status should be directed to 1-800-775-8805.

Access a Coping with Loss resource flyer full of helpful information and advice at https://www.mutualofomaha.com/documents/eap/coping-with-loss.pdf.