

Unimerica Insurance Company

UnitedHealthcare Specialty Benefits
PO Box 7149
Portland, ME 04112-7149
1-866-293-1794
Fax: 1-800-980-0298



PROOF OF DEATH FOR GROUP INSURANCE

INSTRUCTIONS:

1. Claimant please fill in and sign section below.
2. Certified Death Certificate must be included in proofs.
3. Attach copy of police report , if accidental.
4. Attach copy of toxicology report if driver.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a notice of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

SECTION 1

CLAIMANT'S SIGNATURE	
I hereby make claim for the death benefits on the life of:	
Under Group Policy Number 301755 AET	Insured Deceased S.S. Number
If a dependent, name of insured	
Address	
Insured in the (Name of Employer Group)	
Deceased date of BIRTH	Deceased's date of DEATH
Place of death (if in hospital, give name and address of hospital)	
Cause of death	
State your relationship to Deceased	Your Date of birth
Your Name	Your Telephone Number
Your Address	

SIGNATURE AND SOCIAL SECURITY VERIFICATION Please review the following statement and sign your name the way you would ordinarily sign a check. We are requesting your signature for two purposes: first, to certify your Social Security number; and second, to confirm your signature for the bank that will clear your checks.

Under the penalties of perjury, I certify that (1) the number I have documented on this form is my correct taxpayer identification number, and (2) 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 or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.

Social Security Number or Taxpayer Identification Number

Signature
(IMPORTANT: Sign your name the way you would ordinarily sign a check)

Date

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that by furnishing the form and investigating the claim, the United HealthCare Insurance Company shall not be held to admit validity of any claim, or waive any of its rights, or any of the conditions of the policy. I hereby authorize United HealthCare Insurance Company to obtain any medical or hospital records on the deceased. A photostat of this authorization will be as valid as the original authorization.

(OVER)

SECTION 2

STATEMENT OF EMPLOYER

We certify that, to the best of our knowledge and belief, the following statements and answers are true:

Full Name of Employee

Address of Employee	Street Address		
	City	State	Zip

Name of Group

Employee Social Security Number

Date to which Employee's Individual Premiums are paid

Date of Employment

Date of Last Active Service (Performing normal duties on full-time basis)

If Employee not actively at work on date of death, give reason:

- Discharged On Leave of Absence Quit On Vacation On Disability
- Temporary Work Stoppage
- Other, explain _____

Occupation or Class of Insured

Basic Amount of Life Insurance \$

Supplemental Amount of Life Insurance \$

Name of Beneficiary *	Relationship
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*Please attach any enrollment forms and beneficiary designations you retained.

AUTHORIZED OFFICIAL MUST SIGN BELOW:

Name of Employer

Address of Employer

Telephone Number of Employer (with area code)

Signature of Employer