Ullico
SOLUTIONS FOR THE UNION WORKPLACE

PROOF OF DEATH

Please submit this form to:
GROUP LIFE CLAIM DEPARTMENT
The Union Labor Life Insurance Company
8403 Colesville Road • Silver Spring, MD 20910
Toll-free: (866) 795-0680 • Fax: (202) 962-2939

INSTRUCTIONS:

1. Please make certain that all pertinent questions are answered and the proper supporting documents are included before forwarding claim to avoid unnecessary delay in processing the claim.
2. Please submit along with this completed form the following:
   a. proof of insured's eligibility;
   b. a certified copy of the official Death Certificate; and
   c. the original enrollment card with all applicable changes of beneficiary.
3. If Accidental Death benefits are being claimed, provide any police report, autopsy report, newspaper articles or similar document that describes the accident.
4. If benefits are to be paid to a minor beneficiary, a certified copy of the appointment of a guardian of the estate of the minor by the Court is required prior to any payment.
5. If benefits are to be paid to the estate of the deceased, a certified copy of the appointment of the executor or administrator of the estate of the deceased insured by the Court is required prior to any payment.
6. If the designated beneficiary predeceased the insured, a certified copy of the Death Certificate of the deceased beneficiary will be required.
7. If no beneficiary was designated or if the designated beneficiary predeceased the insured, then the insurance becomes payable based on the following order of preference to: surviving spouse, deceased's children, deceased's parents, deceased's brothers and sisters, or to the executors or administrators of the deceased's estate, unless directed specifically by the policy.
8. If more than one beneficiary is entitled to receive the insurance proceeds, the additional beneficiaries should sign below and provide the requisite information.
9. If the decedent was permanently and totally disabled and death occurred more than 31 days after the termination of insurance under the group policy, the beneficiary should complete and have the decedent's attending physician complete the Total and Permanent Disability application (Form No. LHFM-ULL-1141), which should be forwarded with the claim.

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FRAUD NOTICE

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.

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.

Louisiana: 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.

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.

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.

Rhode Island: 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.

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 include imprisonment, fines, and denial of insurance benefits.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefit

I attest that I have reviewed, understand and acknowledge the fraud warning(s).

Member or Claimant's signature: X _____ Date: _____

PLEASE READ AND COMPLETE ALL PAGES

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POLICYHOLDER'S STATEMENT

Claim is hereby filed for the following benefits and amounts.

Insured name: _____

Claim type	**Amount of insurance**	Policy number
Basic Life:	$_____	G- _____
Supplemental Life:	$_____	G-
Accidental Death:	$_____	C-_____

Decedent is: ☐ Active ☐ Retiree ☐ Spouse ☐ Child

Policyholder's Certification:

IMPORTANT: Please provide proof of eligibility when submitting this claim

We certify that the decedent was eligible at the time of death. Proof of eligibility is attached.

Policyholder: _____
Name of Union, Fund, or Employer

By: X _____
Signature and Title

Date: _____

REGARDING THE DECEASED

1a. Name: _____ 1b. SSN: _____

2a. Date of birth: _____ (Month/day/year) 2b. Place of birth: _____ (City/State)

3a. Date of death: _____ (Month/day/year) 3b. Place of death: _____ (City/State)

4a. Date last worked: _____ 4b. Last occupation: _____

4c. Cause of death (In detail): _____

QUESTIONS NO. 5 AND 6 SHOULD ONLY BE ANSWERED IF ACCIDENTAL DEATH CLAIM IS FILED.

5a. Date of accident: _____ 5b. Place of accident: _____

6. Describe fully how the accident occurred and the nature of injuries received: _____

BENEFICIARY STATEMENT (Beneficiary Social Security must be provided)

Full name: _____ Date of birth: _____ SSN: _____

Address/P.O. Box number: _____ City: _____ State: _____ Zip: _____

Day time phone: _____ Evening phone: _____ Relationship to the deceased: _____

I hereby certify that the answers I have made to the questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud warning(s) on page 1 of this form.

BENEFICIARY X _____ Date _____

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For additional beneficiaries complete the information below:

Full name:_____ Date of birth:_____ SSN:_____

Address/P.O. Box number:_____ City:_____ State:_____ Zip:_____

Day time phone:_____ Evening phone:_____ Relationship to the deceased: _____

I hereby certify that the answers I have made to the questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud warning(s) on page 1 of this form.

BENEFICIARY X_____ Date: _____
Signature

Full name: _____ Date of birth:_____ SSN: _____

Address/P.O. Box number: _____ City:_____ State:_____ Zip: _____

Day time phone:_____ Evening phone: _____ Relationship to the deceased: _____

I hereby certify that the answers I have made to the questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud warning(s) on page 1 of this form.

BENEFICIARY X_____ Date: _____
Signature

Full name:_____ Date of birth:_____ SSN:_____

Address/P.O. Box number:_____ City:_____ State:_____ Zip:_____

Day time phone:_____ Evening phone:_____ Relationship to the deceased: _____

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BENEFICIARY X_____ Date: _____
Signature

Full name:_____ Date of birth:_____ SSN:_____

Address/P.O. Box number:_____ City:_____ State:_____ Zip:_____

Day time phone:_____ Evening phone:_____ Relationship to the deceased: _____

I hereby certify that the answers I have made to the questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud warning(s) on page 1 of this form.

BENEFICIARY X_____ Date: _____
Signature

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