



**Return to Fort Dearborn Life at:**  
Attention Claims Department  
P.O. Box 655403  
Dallas, Texas 75265-5403

**Phone Number:** (800) 778-2281  
**Fax:** (972) 996-9361

**INSTRUCTIONS — ANSWER ALL QUESTIONS FULLY AND SUBMIT ALL NECESSARY ATTACHMENTS TO AVOID UNNECESSARY DELAY AND CORRESPONDENCE**

Upon the death of the insured employee, member or insured dependent, the employer must complete the claim form as indicated below and send with all attachments to the address above.

Complete the Statement of Employer fully and have signed by an authorized officer of the Group Policyholder.

**Attachments:**

You must submit a **certified copy of the official death certificate** together with this claim form.

In addition to the above requirement, please submit the original enrollment form and all applicable **changes of beneficiary**.

If the life insurance benefit is based on salary, please submit **payroll records verifying the employee's annual earnings** at the time of death.

If any portion of the life insurance coverage is contributory, please submit proof of payroll deduction.

**STATEMENT OF EMPLOYER**

Name of Employee		Name of Decedent	Maiden Name	Alias Name	Dependent Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employee Address			Employee Job Title/Occupation	Decedent's Date of Birth	
Group No.	Employee SS No.	Ins. Class No.	Basic Annual Earnings \$	Amt. Of Insurance Being Claimed	
Did deceased have Accidental Death & Dismemberment Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are AD&D benefits being claimed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", attach newspaper clipping and police report.		\$ _____ Basic	
Did decedent die in a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, was decedent wearing a seat belt? <input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____ Supplemental	
If the answer to the preceding question was yes, a copy of the <b>police report must be attached.</b>				\$ _____ AD&D	
				\$ _____ Voluntary	
				\$ _____ Dep.	
				\$ _____ Other	
Date of Death	Place of Death	Cause of Death			
If contributory insurance, to what date has the employee's contribution been paid? Date _____					
Beneficiary (if estate, certified copy of court order appointing executor or administrator should be attached)					
Name _____		Social Security No. _____		Relationship _____ Age _____	
Address _____		Phone No. (____) _____			
If the designated beneficiary is deceased, please furnish a certified copy of his/her death certificate.					
Guardian (If beneficiary is a minor, a certified copy of the court order appointing guardian of minor's estate should be attached)					
Full name _____		Address _____			
Date Employed	Date Employment Terminated	Reason for stopping work: <input type="checkbox"/> Resignation <input type="checkbox"/> Retirement <input type="checkbox"/> Illness <input type="checkbox"/> Layoff <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Vacation <input type="checkbox"/> Other (explain briefly)			
Employee's last day of full-time, active work for employer.		If due to illness/injury, disability benefits were paid: From _____ Through _____ Carrier's Name _____			
Do you recommend payment of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No		Remarks:			
Group Policyholder Name			Telephone No. (____) _____	Fax No. (____) _____	
Street Address			City	State	Zip
Completed by (Please type or print)			Signature of Policyholder's Representative/Title		Date

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 INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. (Not enforceable in Oregon and Virginia.)



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

**Arizona & New Jersey - Claims**

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

**Arkansas & Massachusetts**

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.

**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 & Oklahoma**

Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

**District of Columbia & Virginia**

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 & 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.

**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 - Applications**

Any person who knowingly files false or misleading information on an application for insurance coverage is subject to criminal and civil penalties.

**Texas**

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.

**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.

**All Other States**

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. (not enforceable in OR)