Companion Life Insurance Company
Group Life Claims
3316 Farnam Street
Omaha, NE 68175-5102
Toll Free (800) 775-8805
Fax (402) 997-1835
Email submitgrplife@mutualofomaha.com

Mutual of Omaha

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. If the benefit amount is $200,000 or less, a copy 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:

Companion Life Insurance Company
Group Life Claims
3316 Farnam Street
Omaha, NE 68175-5102
or
Fax number: (402) 997-1835
Email: submitgrplife@mutualofomaha.com

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.

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 deceased _____

   Name of employee/member (If not the deceased person)_____

2. Date of death _____ Date of birth _____ Age_____

3. Social Security number of deceased _____

4. Employee's/member's marital status
   ☐ Single ☐ Married ☐ Widow/widower ☐ Separated ☐ Divorced ☐ Domestic partner relationship ☐ Civil union

5. Amount of insurance: Basic life _____ Basic AD&D _____
   Voluntary life _____ Voluntary AD&D _____
   Supplemental life _____ Voluntary dependent AD&D _____
   Basic dependent life_____ Voluntary dependent life _____

6. Date premium for the above deceased has been paid through_____

7. Date employee's employment or member's membership began: Full time_____ Part time _____

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

8. Effective date of deceased's insurance with Mutual of Omaha or United of Omaha_____

9-13 required for employee and/or dependent claims.

9. Date on which the employee was last present at work?_____

10. Reason for employee ceasing work
    ☐ Illness (Including disability leave of absence/partial disability) ☐ Leave of absence (Other than disability)
    ☐ Quit ☐ Dismissed ☐ Vacation ☐ Retired (Date)_____ ☐ Layoff ☐ Deceased ☐ Accident

11. Was the employee disabled? ☐ Yes ☐ No

    If yes, date disability began _____ Date partial disability began_____

12. Employee was: (Check all that apply) ☐ Full time ☐ Part time
    ☐ Union ☐ non-Union ☐ Hourly ☐ Salaried ☐ Exempt ☐ non-Exempt ☐ Other (Explain) _____

13. Average hours employee worked per week:_____ Occupation _____ Class _____

14. Name of beneficiary as shown on your records _____ Relationship _____
    Attach enrollment record plus any beneficiary changes (In written or electronic format)

Attach beneficiary designation form plus any beneficiary changes.

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_____ Date _____

Signature of authorized employer/plan representative_____

Phone number _____ Fax 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 _____

If the deceased was an employee/member, fill out the following:

Was the employee/member disabled? ☐ Yes ☐ No If yes, date disability began _____

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:

Dependent's occupation _____

Was the dependent disabled? ☐ Yes ☐ No

If yes, 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.

Your signature _____ Date _____

Printed name _____

Authorization To Disclose Personal Information – New York

1. I authorize physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, insurers, employers, consumer reporting agencies and all other providers of medical and dental services to release Personal Information to representatives of Companion Life Insurance Company for:

   Deceased name _____ Deceased date of birth _____

2. Personal Information includes: medical history, mental and physical condition, prescription drug records, alcohol and drug use, financial and occupational information.

3. The Personal Information will be used to evaluate my claim for benefits.

4. If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

5. I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

6. This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to: ATTN – Group Life Claims, Companion Life Insurance Company, 3316 Farnam, Omaha, NE 68175-5102. Any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

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

_____ _____

Signature of claimant or individual authorized to represent the deceased

Date

_____ _____

Printed name

Relationship to deceased

Address _____ _____

(Street)

Phone number

_____

(City) (State) (ZIP code)