Proof of Death Form

Please Return Completed Form To:
Companion Life Insurance Company
Group Life Claims
3316 Farnam Street
Omaha, NE 68175-5102
Toll Free 1-800-775-8805

Instructions for Furnishing Proof of Death

1. Beneficiary or other claimant should complete Part II. Attach certified copy of deceased's Death Certificate and return to Policyholder or Group Administrator for completion of Part I.
2. If any beneficiary, other than a contingent beneficiary, died before the Insured, a copy of the Certificate of Death of such beneficiary must be attached to the proofs. In such case, claim should be made by the other beneficiaries, or if there be none, by the duly appointed representative of the Insured's estate.
3. If claim is made on behalf of the estate of the deceased, a certified copy of the Letters of Administration must be attached to the proofs.
4. If any beneficiary is a minor or legally incompetent, a certified copy of the appointment of a guardian must be attached to the proofs.
5. **Important:** Attach enrollment record plus any beneficiary changes.

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.

Authorization To Disclose Personal Information

To 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 or dental services.

I authorize you to release to representatives of Companion Life Insurance Company, personal information about the insured person including: medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information in order to evaluate my claim for benefits.

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.

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.

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, Mutual of Omaha Plaza, Omaha, NE 68175-0001. Any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

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

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

_____

_____	_____	_____
Printed Name of Insured Person	Printed Name of Authorized Person	Signature of Authorized Person
_____	_____	
Relationship to Insured	Date	

Part I Statement of Policyholder or Group Administrator

Employee ☐ Spouse ☐ Child ☐ Other ☐

1. Full name of deceased _____ Soc. Sec. No. _____ Eff. date of deceased insurance _____

   Name of Employee _____ Soc. Sec. No. _____ Eff. date of employee's insurance _____

2. Date employment began _____ Occupation at time of death _____
3. Date of last active work _____ If retired, date retired _____
4. Premium for the above deceased has been paid through _____
5. If date deceased last worked was more than 31 days prior to death, was deceased:
   totally disabled? ☐ on leave of absence? ☐ on temporary layoff? ☐
6. If benefits are based on earnings, give amount of monthly earnings _____
   (Note: We may require supporting documentation of earnings and paid premiums to process the claim.)
7. If your plan has more than one class, show class deceased was covered under _____
8. Name of beneficiary shown on your records _____ Relationship _____

   Note: Attach Enrollment Record 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 for the amount of $_____.

Master Policy No. _____ _____
Name of Policyholder

Date _____ By _____
Signature and Title

Part II Statement of Beneficiary or Other Claimant

1. Full name of deceased _____
2. Date of birth of deceased _____ Your date of birth _____
3. Your relationship to insured _____ Your telephone no. (____) _____
4. Your address _____
   Street City or Town State ZIP Code
5. If you are not the named beneficiary, in what capacity do you make this claim? _____
   _____
6. Your (Claimant's) Taxpayer Identification Number
   For exempt payees write "Exempt" here _____

   Social Security Number _____ - _____ - _____ OR Employer Identification Number _____ - _____

   CERTIFICATION — Under penalty of perjury, I certify that:
   (a) The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me); 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.
7. Does the deceased have any other life insurance coverage with Mutual of Omaha? Yes ____ No ____

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_____ ____/____/____ _____
Signature of Claimant Date Relationship To Insured

Mailing Address of Claimant

_____ _____
Street City State ZIP Code