Monumental Life Insurance Company
Claims Department
Administrative Office: Valley Forge • Pennsylvania 19493
Phone: 1-866-227-0379

Dear Claimant,

On behalf of our company, we wish to express our sincere condolences on your loss.

We hope that we may assist you in this time of uncertainty by making the insurance claim process as uncomplicated as possible.

Enclosed is a **Claim Form**. This form should be completed in its entirety. Please be sure to sign all the **Authorizations**.

*** * * * ***

If you are filing a claim for Accidental Death Benefits, you also need to have the Attending Physician complete and sign the **Statement of Attending Physician.** In addition, please submit any police accident reports, ambulance reports, autopsy and any newspaper articles regarding the accident, if available. Again, this information is only needed if you are filing a claim for Accidental Death benefits.

*** * * * ***

Please return the completed forms in the enclosed envelope at your earliest convenience. As soon as all the requested information is received, we will proceed with our evaluation of this claim for benefits.

If you have any questions, please do not hesitate to contact us at the toll-free customer service number listed on the bottom of the **Insurance Claim Filing Instructions** sheet. We are here to help you in any way we can.

FRAUD WARNING NOTICES

Any person who knowingly and with intent to defraud, injure or deceive an insurance company or other person files a statement of claim or application containing any materially false or misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a crime and may be subject to civil penalties, fines, and/or imprisonment.

Alaska, **Minnesota**, **New Hampshire**: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arkansas, **Louisiana**, **Maryland, New Mexico, Texas, West Virginia**: 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.

Arizona: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

Colorado: **It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any 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.**

Maine, **Virginia**, **Tennessee, Washington**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company 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.

Delaware, **Idaho**, **Indiana**: Any person who knowingly, and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false or misleading information is guilty of a felony.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self insured program files a statement of claim or an application containing any false or misleading information commits insurance fraud, punishable as provided in section 817.234.

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 the claim was provided by the applicant.

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

Kentucky, 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.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy 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 violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oregon: Any person who knowingly and with intent to defraud, files a claim for benefits may be guilty of insurance fraud and may be subject to prosecution.

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CLAIM FORM

DECEASED INFORMATION		
Name: (Last, First, Middle)	Was the deceased known by any other name? NO ☐ YES ☐ If yes, list other names:	
Address:	Date of Birth:	Date of Death:
City/State/Zip:	Cause of Death:	
Policy/Certificate Number(s):	Social Security #:	Driver's License #:

CLAIMANT/BENEFICIARY INFORMATION		
Name:	Relationship to Insured:	Date of Birth:
Address:	Daytime Phone:	
City, State, Zip:	Social Security Number:	

Your Citizenship: (_____) U.S. (_____) Other (If Other, list name of country)

DOES THE DECEASED HAVE OTHER INSURANCE?		
Insurance Company:	Benefit Amount:	Policy/Certificate #:

MEDICAL HISTORY --- LIST MEDICAL TREATMENT IN THE LAST 5 YEARS			
Name of Hospital or Physician:	Condition / Dates of Service:	Address:	Phone:

CLAIM DETAILS (ONLY NEED TO COMPLETE IF FILING FOR ACCIDENTAL DEATH BENEFITS)

How, where did accident happen? What injuries were received? *(Describe fully)* Please list names/addresses/phone numbers of all doctors and hospitals that provided treatment for this incident:

Names and addresses of all eyewitnesses to accident:

If Police Report is not attached, please give name, address & phone number of Police Department that investigated this case:

Name of Investigating Officer: Phone: ( )

If Autopsy/Inquest is not attached, please list name, address & phone number of the organization performing Autopsy/Inquest:

Name, address and phone number of Pharmacy used by deceased:

AUTHORIZATION (Signature required)

I, the undersigned, declare that to the best of my knowledge, all answers recorded are complete and true. I have not been notified by the Internal Revenue Service that I am subject to a backup withholding order on interest or dividends.

I, the undersigned, authorize any hospital, physician or insurance company, employer or association to furnish Monumental Life Insurance Company and their representatives any and all information with respect to any illness or injury, medical history, consultation, prescription, or treatment and copies of all hospital or medical records (or Photostats thereof) of the deceased named above, to determine eligibility for benefits under an existing policy/certificate. This authorization is valid for the duration of the claim and a photo static copy shall be considered as valid as the original.

_____ _____
Authorized Signature Date

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Insurance Claim Filing Instructions

PROOF OF DEATH SHALL CONSIST OF THE FOLLOWING PAPERS:

1. A completed and signed claim form. *Form will be returned if not signed and/or citizenship question is not answered.*
2. Certified Death Certificate. (Please note, we cannot accept a photocopy of this document)
3. The original policy/certificate(s) and rider(s) upon which the claim is made.
4. Evidence of change of name of Insured or beneficiary (if applicable).

A PROPERLY COMPLETED CLAIM FORM WILL ASSIST US IN THE PROMPT PROCESSING OF YOUR CLAIM

Return Proofs of Death (*listed above*) to:

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Note: If you need additional space in order to complete the claim form, please attach a separate sheet of paper with your responses.

The form must be completed by the named beneficiary(ies). If the amount payable is to be divided among more than one beneficiary, you may photocopy this entire claim packet and then have each beneficiary complete their own claim form.

Include the social security number and/or the appropriate tax identification number for each beneficiary/payee.

When manner of death was due to an accident, suicide or homicide, we require a completed Statement of Attending Physician, a copy of the police report, emergency medical services report, coroner's report, autopsy report and accident report if available or the name, address and telephone number of the office where this information can be obtained.

When death occurs outside the United States, a certified copy of the Official Record of Death must be furnished.

IF THE BENEFICIARY…

has assigned the benefits, the claim form must be completed by the beneficiary who must submit the original assignment form. The assignment form must include a statement of the amount claimed by the assignee that is agreed to by the beneficiary.

is someone who died before the Insured, a copy of the death certificate for the deceased beneficiary must be furnished. (When there is no contingent beneficiary named, the policy/certificate explains who will be paid if the beneficiary dies before the Insured. In many cases it is the estate of the Insured).

is the estate of the Insured, this claim form must be completed by an executor or administrator and a certificate of appointment and authority must be furnished.

is a minor, the claim form must be completed by the minor's legally appointed guardian and a certificate of appointment and authority must be furnished.

is a firm or corporation, the claim form must be completed by a duly qualified officer who has the power and right to make such claim in the name of the firm or corporation.

is a trust, the claim form must be completed by the trustee of the trust. A certified copy of the document appointing the trustee of the trust must be furnished.

This claim form has been sent to you as requested in anticipation of a claim being filed. We will be unable to begin processing your claim until all completed forms and documents are received by Monumental Life insurance Company. If we do not receive the completed claim form within 30 days of your receipt of the claim form, we will assume you no longer wish to file a claim. If you need assistance, please contact us at the toll free number as noted below.

NOTICE TO ILLINOIS INSUREDS

If an Insured was issued a policy/certificate in Illinois or was a resident of Illinois at the time of death, interest will accrue on the proceeds payable because of the death of the Insured starting from the date of death. The rate of interest will be 9% on the total amount payable, or the face amount if payments are to be made in installments, until the total payment or first installment is paid, unless payment is made within thirty (30) days for Accidental Death claims and fifteen (15) days for Term/Whole Life Insurance claims, from the date of receipt by the company of due proof of loss. If payment is made within the 15/30 days of the receipt of due proof of loss, the 9% interest is not payable.

If you have any questions regarding what is required, please call us toll free at 1-866-227-0379

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize _____**(hospital/doctor/other medical provider)** to use or disclose the following protected health information from the medical records of the patient identified below. I understand that information used or disclosed pursuant to this authorization could be subject to **re-disclosure** by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. You are hereby authorized to give to the Company specified below, or its representatives, copies of any records or data which have to do with the **physical or mental health including drug, alcohol, psychiatric, HIV infection or AIDS related treatment**. A photo static copy of this authorization shall be considered as effective and valid as the original.

Patient Name: _____ Date of Birth: _____

Social Security Number**:** _____ Date of Death: _____

Address: _____

Information to be disclosed to: Monumental Life Insurance Company
Or their Representative (EMSI, Source Access and/or Exam*ONE*)

FOR OFFICIAL USE ONLY:

Disclose the complete records including the following information for treatment dates**:** _____ to _____**:**

☐	Admission Summary	☐	Consults	☐	Office Records	☐	Death Summary	☐	_____
☐	Discharge Summary	☐	X-Ray	☐	Emergency Reports	☐	Toxicology	☐	_____
☐	History & Physical	☐	Laboratory	☐	Operative Reports	☐	Autopsy		
☐	Outpatient Reports	☐	Pathology	☐	EMS Report	☐	Medications		

The above information is disclosed for the purpose of processing an insurance claim.

I understand I may **revoke this authorization** at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

This authorization **expires 2 years from the date signed**; unless otherwise noted here: _____.

IMPORTANT – If patient is deceased, please INITIAL one of the statements below:

_____ I am the Administrator/Executor for the deceased & Letters of Testamentary (or comparable documents) are attached.
Initial here

_____ There is no court appointed Administrator/Executor and I am the next of kin.
Initial here

I understand that I am not required to sign this authorization. The above named health care provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

I also authorize any doctor, hospital, or other medical or medically related facility, treatment center, recovery center, insurance company, consumer reporting agency, employer, Social Security Administration or any other organization or person having any knowledge of the patient named above, including financial institutions, and law enforcement agencies to give Monumental Life Insurance Company or its authorized representative any information needed to determine policy/certificate claim benefits. This may include (but is not limited to) information regarding HIV antibody testing, Acquired Immune Deficiency Syndrome or related complexes, driving records, financial records, police or accident reports, mental illness and use of alcohol or drugs.

_____ _____
Signature of Legal Representative **Date**

_____ _____
Printed name of Legal Representative **Relationship or authority to act for Patient**

_____ _____
Witness **Date**

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS

STATEMENT OF ATTENDING PHYSICIAN
(Only needs to be completed if filing an Accidental Death claim.)

In relation to the death of _____, of _____
(address)

1. How long has the Insured been your patient?
2. Date of death Month Day Year Hour
3. Was there an injury or illness? If yes, when? Month Day Year
4. On what date did you first attend deceased for the above condition? Month Day Year
5. Describe his/her condition at that time?
6. Between what dates did you treat deceased? From To
7. If an injury, how did the injury occur?
8. What was the precise nature and extent of the injuries? *(Describe fully all visible evidence)*
9. Was an alcohol and/or drug screen performed? ☐ No ☐ Yes If yes, when and where?
10. Was the Insured confined in a hospital? ☐ No ☐ Yes If yes, name and address of hospital: From To:

_____
Attending Physician Signature Date

_____
Physician's printed name

_____
Street

_____
City, state, zip code

_____
Telephone Number

_____
FAX Number