Sentinel Security Life

*Lighting the way to financial security*

# LIFE INSURANCE CLAIM FORM

| NAME OF DECEASED: | POLICY NUMBERS |
|---|---|
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**A Message to Our Sentinel Life Beneficiaries**

On behalf of Sentinel Security Life, please accept our sincere condolences for your loss. We realize that this is a difficult time for you and your family, and we will make every effort to process your claim promptly. We take pride in assisting our beneficiaries. To expedite the processing of your claim, it is important that it contain all of the necessary information as requested in the Claimant's Statement Pages 2 through 4.

**The following documents, where applicable, will be required to receive payment of the policy proceeds. Please review this checklist prior to submitting your claim:**

- ☐ Complete all sections of the Claimant's Statement
- ☐ Obtain a certified copy of the insured's death certificate. The funeral director often provides one or assists in this area. Note: Only one certified death certificate is required per insured with multiple claimants and/or policies. The Death Certificate will be returned upon request. **(Required)**
- ☐ Provide a legible copy, color preferred, of driver's license or state issued identification card. **(Required)**
- ☐ If the claim form is being completed by an Administrator, Executor, or a Legal Guardian, a Court Certificate of Appointment must be submitted with the Claimant's Statement. **(Where Applicable)**
- ☐ If the funds are to be paid directly to a Funeral Home, Mortuary or another party, it will be necessary for the claimant/beneficiary to sign the Assignment of Benefits on Page 2 Section C. Please include a Statement of Services if paid to a Funeral Home or Mortuary. Any difference payable between the amount paid to the Funeral Home or Mortuary if any, shall be paid directly to the claimant/beneficiary(ies). **(Where Applicable)**
- ☐ **Review the "Fraud Warning" applicable to your state**

Although every effort is made to ensure prompt payment of benefits, your claim may be delayed if additional information is required to comply with the Company's claim procedures for Federal and State Law. We will notify you immediately if we need additional information.

Should you need assistance in completing this claim, please call Policy Services toll free at 800-247-1423.

**PLEASE NOTE: WE RESERVE THE RIGHT TO MAKE FURTHER INQUIRIES**

Please retain this page for your information

**P.O. Box 27248, Salt Lake City, UT 84127-0248 • Phone: 800-247-1423 • Fax: 801-484-2459**

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**Section A - Read this section carefully if the named beneficiary(ies) is not alive.**

1. If the last known beneficiary(ies) of the policy(ies) has died, please send us a copy of the beneficiary death certificate.
2. Please provide the name and address if funds are to be paid equally to each named beneficiary. Use the back of the sheet for additional names and addresses.
3. In the event a Trust is listed as the primary beneficiary the funds will be paid as designated, unless as signed by the named Trustee.

**Section B - Claimant/Beneficiary(ies)of the death benefit proceeds (i.e., individual, company, executor or trustee, whichever is applicable for this policy(ies).**

2. a) Name: _____

b) Street Address: _____

c) Mailing Address: _____
(if different from Street Address)

d) Relationship to Insured: _____

e) Telephone Number(s): _____

f) Best Time to Call: _____ at ☐ **Home** ☐ **Business**

g) Date of Birth: _____

h) Social Security Number: _____

**Section C - ASSIGNMENT OF BENEFITS (To be completed by the Claimant/Beneficiary(ies) if proceeds are to be paid to the Funeral Home, Mortuary or Other as named).**

I the undersigned beneficiary(ies) hereby assign and transfer to _____

Address: _____

The sum of the proceeds not to exceed $_____ subject to provisions in the policy(ies). This assignment is valid only if the policy was in force at the time of the insured's death. I certify that I am the beneficiary(ies) designated in the policy. The payee named in this assignment guarantees the signature and identity of the beneficiary(ies).

_____
**Date**

_____
**Signature of Claimant/Beneficiary(ies)**

_____
**Address**

_____

_____

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# LIFE INSURANCE CLAIM FORM

**THIS FORM IS REQUIRED ON ALL CLAIMS**
**THE CLAIMANT IS RESPONSIBLE FOR COMPLETION**

**NAME OF DECEASED:**

**Section D: STATE FRAUD WARNINGS**

**Alaska, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, New Mexico, Ohio, Oklahoma, Oregon, Tennessee, Texas, Virginia, Washington, West Virginia and All Other States not listed:** Any person who, knowingly with intent to defraud any insurance company or other person files a 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 may subject such person to criminal and civil penalties, and denial of insurance benefits.

**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 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.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**New Hampshire:** Any person who, with the 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:** 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 a 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.

**Section E: List names of all hospitals and/or doctors and institutions, if any, Deceased visited during his/her last illness and during the three (3) years prior to that illness. Also list date of visit and condition(s) treated. If more space is required please use the reverse of this page.**

| Hospital/Doctor | City, State, Zip | Date of Visit | Condition | Telephone No. |
|---|---|---|---|---|
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**I certify the above is complete and true and that I have read the Fraud Statement**

Date _____ Signature of Claimant/Beneficiary(ies) _____ Relationship to Deceased _____

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# LIFE INSURANCE CLAIM FORM

**THIS FORM IS REQUIRED ON ALL CLAIMS**
**THE CLAIMANT IS RESPONSIBLE FOR COMPLETION**

**NAME OF DECEASED:**

## Authorization to Release Confidential Medical Information

Records and information obtained will be disclosed to Sentinel Security Life Insurance Company for the purpose of evaluating my application for insurance or claim benefits.

I hereby authorize you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, Genetic Testing, Sickle Cell testing and treatment, Lab data and EKG's.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, or anyone else to release any and all records and, information to be exchanged between the insurance company named above and their agents, contractors, employees, representatives, affiliates, and assigns as necessary to fulfill the purpose of this disclosure.

**I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization at any time by requesting such of the providing organization in writing at the address stated below, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.**

**Providing Organization:**

_____ _____

Signature of Claimant/Beneficiary(ies) Date

_____

Relationship to Deceased

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# LIFE INSURANCE CLAIM FORM

## SETTLEMENT OPTIONS

**PROCEEDS.** Amounts of $2,000 or more which are payable from this policy may be applied under any of the following options:

**Option 1. Left at Interest.** We will pay a periodic income equal to the interest on the proceeds left on deposit with us.

**Option 2. Installments for a Fixed Period of Years.** Payment will be made for a fixed period not to exceed 30 years.

**Option 3. Installments for a Fixed Amount.** Payments of a fixed amount will be made until the proceeds and interest has been fully paid. Total payments made for each year must not be less than 4% of the original proceeds applied.

**Option 4. Lifetime Income.** We will pay an income for the life of the payee with no refund of any amount at the death of the payee.

**Option 5. Lifetime Income with Payments Guaranteed for a Fixed Period.** We will pay an income for the life of the payee with payments guaranteed for 10 to 20 years. Upon the payee's death, we will pay the withdrawal value of the unpaid guaranteed payments, if any.

**CONDITIONS.** Election of any option is subject to the following conditions:

1. Election must be made by the owner while the insured is living. If no election is made by the time of the insured's death, then the beneficiary may elect an option.
2. A change of beneficiary after election of an option revokes any prior designation.
3. An installment or interest payment must be at least $20.
4. Options are available only with Sentinel's consent if: (a) this policy is assigned; or (b) the payee is a trustee or business entity.
5. We may require proof of the payee's age under Options 4 and 5. We also may require proof that the payee is living at the time any payment is due.

**SETTLEMENT AGREEMENT.** At the time the payments are to begin, we may require exchange of this policy for a contract which covers the settlement agreement. The effective date of the agreement will be the date proceeds are applied to an option.

**BASIS OF INCOME OPTIONS.** The guaranteed interest rate is 2%. Additional interest may be paid as determined by Sentinel. The interest rate used to compute income payments will also be used to determine the withdrawal value of the guaranteed payments that remain unpaid at the payee's death. Life income option amounts are based on the Annuity 2000 Mortality Table.