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Life Insurance Claim Submission Instructions

Please fax or mail this claim to:
Wisconsin Manufacturers & Commerce
501 East Washington Avenue
Madison, WI 53703-2914
Phone: 1-800-236-5414
or locally at 1-608-258-3400
FAX: 1-608-258-3413

In order to ensure timely and accurate processing of the life insurance claim, *please include the following with your claim submission*:

- **Proof of Death Claim Form** - Completed and signed by the employer/authorized employer representative. (The proof of death claim form cannot be filled out or signed by the insured/employee, or a beneficiary.)

- **Death Certificate** - *Copy* of the certified Death Certificate including cause and manner of death (the original death certificate is not required, a faxed *copy* is sufficient).

- **Beneficiary Designation** - Most *Current* Beneficiary Designation Form, Card, or Electronic Screen-print that names the insured's beneficiaries. This designation should be on file with the employer or Aetna.

- **Enrollment** - For Employee contributory or supplemental life coverage, please include the current and prior two years enrollment forms based upon date last worked, enrollment confirmation statements, or system screen-prints from your enrollment system showing the insured was enrolled in the contributory or supplemental life coverage.

Questions?
We're here if you need us. You can call our Customer Service Center toll-free at **1-800-236-5414**. We're happy to help you. Our Customer Service Center hours are Monday through Friday, 8 a.m. to 7 p.m., ET.

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Life Insurance Claim Submission Checklist

Please fax or mail this claim to:
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Proof of Death Form Reminders

- ☐ **Proof of Death Claim Form** (***all sections completed and signed by employer/employer representative***)
  - ☐ **Physical Date Last Worked and Reason for Physical Date Last Worked**
  - ☐ **For Salary Based Benefit Calculations, salary (as of physical date last worked)**
  - ☐ If Age Reductions were applicable, did you factor those into the benefit calculation?
  - ☐ Did you check the Yes or No box on the question "**Were premiums paid through the date of death for this insured**"?

Death Certificate Reminders

- ☐ Copy of the Insured's/Dependent's certified **death certificate** *(with the cause and manner of death)*

Beneficiary Designation Form / Card / Screen-print Reminders

- ☐ Most recent **beneficiary designation form**
- ☐ If the beneficiary is a **minor child**, provide: A copy of the birth certificate & Social Security Card
- ☐ If the designated **beneficiary has died**, provide: A copy of the beneficiary's death certificate
- ☐ If **no beneficiary was named or no beneficiary survives the insured** and your policy provides for payment to next of kin, please submit: A notarized Aetna Affidavit of Sole Survivors completed by a family representative

If the **beneficiary is the insured's *estate***, provide:

- ☐ Letters of administration / testamentary (Court Papers naming the Administrator / Executor) along with the Estate EIN (Tax ID # of the Estate)

If the **beneficiary is a *trust***, provide:

- ☐ Copy of the Trust, Any Amendments to the Trust, and the Trust Tax ID number (if TIN is available)

Proof of Enrollment for Employee Contributory Life Coverage

- ☐ **Enrollment forms or screen prints confirming *contributory* coverage** elections for the 3 most recent annual enrollment periods (in other words, current and prior 2 years). If Aetna's plan effective date is 3 years or less, include current and most recent prior carrier enrollment forms.
- ☐ Please check if there was a **family status change** (marriage, birth, adoption) and include the family status change date: _____/_____/_____

Accidental Death Reminders

If **Accidental Death** benefits are being claimed, please provide:

- ☐ police/accident report ☐ autopsy report ☐ available newspaper articles concerning the accident
- ☐ toxicology report (not required if the deceased was a *passenger* in a motor vehicle accident)

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Proof of Death
Group Life Insurance and Group Accidental Death Benefit Request

Please fax or mail this claim to:
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501 East Washington Avenue
Madison, WI 53703-2914
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or locally at 1-608-258-3400
FAX: 1-608-258-3413

A. Information About the Deceased *(Please complete all sections)*

Deceased's Name (Last, First, Middle Initial)			If deceased is known by any other name, provide Name (Last, First, Middle Initial)		
Relationship to Employee	Social Security Number	Birthdate (MM/DD/YYYY)	Date of Death (MM/DD/YYYY)	Age	Gender ☐ Male ☐ Female
Last Residence: Street		City		State	ZIP

B. Information About the Employee *(Please complete all sections)*

Employee's Name (Last, First, Middle Initial)		Employee's Social Security Number		Birthdate (MM/DD/YYYY)
Last Residence: Street		City	State	ZIP
Date Employed (MM/DD/YYYY)	Work Location Name/Number	Occupation/Class		☐ Hourly ☐ Salary
Physical Date Last Worked (MM/DD/YYYY)	Reason employee did not return to work after **physical** last day worked. ☐ Retirement ☐ Employee's Own Illness/Injury ☐ Death ☐ Not Applicable (Dependent Death) ☐ Other: _____			

Who reported this death? Contact information of the individual who reported this death. (If the employee reported the dependent's death, enter "see above section B".)
Name & Relationship: _____
Address, Phone Number, Email: _____

C. Employer's Contact Information *(Please complete all sections)*

Employer's Company Name	Employer Representative's Contact/Submitter Name	
Employer's Street Address	Employer Representative's Email Address	
Employer's Telephone Number and Direct Extension	City, State, and ZIP	Employer's Fax Number

D. Information About the Employee's Coverage *(Please complete all applicable sections)*

Coverages for which benefits are in effect and being claimed:

Group Coverage	Control Number (6 digits)	Suffix (2 digits)	Account (3 digits)	Plan (2 digits)	Effective date of Employee's insurance (MM/DD/YYYY)	Amount of insurance in force as of the date last worked
☐ Employee Basic Life					/ /	$
☐ Employee Supplemental Life					/ /	$
☐ Dependent Basic Life					/ /	$
☐ Dependent Supplemental Life					/ /	$
☐ Accidental Death					/ /	$
☐ Accidental Death Supplemental					/ /	$
☐ Paid-Up Life					/ /	$
☐ Group Universal Life (GUL)					/ /	$
☐ Other (please explain)					/ /	$

If insurance is based on earnings, what is the basic rate of earnings as of the **physical** date last worked? (This amount is what you used to calculate the salary based benefit.)
$ _____ per ☐ **Year** or ☐ **Hour** or ☐ **Month** or ☐ **Week**: Provide number of hours worked per week: _____

If insurance is based on **other** earnings, identify type (i.e., commission, bonus, **highest historical**) and amount. Type _____ $ _____	Date of Last Salary Increase (MM/DD/YYYY)	Were premiums paid through the date of death for ***contributory*** coverage for this insured? ☐ Yes ☐ No

Are Employees required to complete enrollment every year for **contributory** coverage? ☐ Yes ☐ No Has amount of **contributory** coverage increased (other than salary) within the last two years? ☐ Yes ☐ No If **yes**, give date ( ) and reason for increase.	If insurance is not in effect, give date discontinued and reason.

Other Comments:

Deceased Information

Name (Last, First, Middle Initial)
Social Security Number

E. Information about the Beneficiary(ies)

Do you have a life insurance beneficiary designation on file? This beneficiary designation should be on file with the employer or Aetna. If not, please contact Aetna to explain.

☐ **Yes** ☐ **No** **If yes, please submit a copy of the most recent designation.**

	Beneficiary #1.	**Beneficiary #2.**	**Beneficiary #3.**
Name			
Street Address			
Street Address 2			
City			
State/ZIP			
Social Security Number			
Relationship to Employee			
Birthdate			
Home Number			
Cell Number			
Work Number			

	Beneficiary #4.	**Beneficiary #5.**	**Beneficiary #6.**
Name			
Street Address			
Street Address 2			
City			
State/ZIP			
Social Security Number			
Relationship to Employee			
Birthdate (MM/DD/YYYY)			
Home Number			
Cell Number			
Work Number			

Is there a Funeral Home / Cemetery Assignment or Funeral Home / Cemetery Re-assignment? (The Funeral / Cemetery Assignment should include Aetna's name and the control/policy #.)

☐ **Yes** ☐ **No** **If yes, please submit copy of the Funeral Home Assignment.**

Please indicate the Funeral Home Name, Address, Phone, and Tax ID Number (if available):

Name: _____

Address: _____

Phone: _____

Has ownership of the life insurance policy been assigned to another party (*this does not mean a funeral home assignment*)?* (If yes, please send a copy of the assignment of *ownership*.)

☐ Yes ☐ No

F. Benefit Distribution Instructions

Return the benefit payment directly to:

☐ Beneficiary(ies) ☐ Other _____ ☐ *Employer (Checkbook to Beneficiary Only)*

G. Comments Section / Benefit Calculation Explanation

****Reminder****

Please submit the completed proof of death form, death certificate, beneficiary designation (if applicable), and enrollment information (if applicable), in order to ensure timely processing of the claim.

Deceased Information

Name (Last, First, Middle Initial)
Social Security Number

H. Employer's Authorized Representative

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents**: 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. **Attention California Residents**: For your protection, California law requires notice of the following to appear on this form: 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. **Attention Colorado Residents**: 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. **Attention Florida Residents**: 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. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** 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**. **Attention Louisiana Residents**: 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 is guilty of a crime and may be subject to fines and confinement in prison. **Attention Maine and Tennessee Residents**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. **Attention Maryland Residents**: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention Missouri Residents:** 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, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law. **Attention New Jersey Residents**: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention New York Residents, the following statement applies only to your AD&D coverage**: 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Attention North Carolina Residents**: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio Residents**: Any person who, with intent to defraud or knowing 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. **Attention Oklahoma Residents**: 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. **Attention Oregon Residents**: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Pennsylvania Residents**: 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. **Attention Puerto Rico Residents**: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Texas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Vermont Residents**: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents**: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington Residents**: 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.

Employer Representative Name: _____

Employer Representative Signature: _____

Date (MM/DD/YYYY): _____ Employer Phone Number and Extension: _____