



## Life Insurance Benefit Claim Form

### Claim Filing Instructions

This Statement for Life Insurance Benefits includes the forms required to apply for Life Insurance benefits. **If a form is received incomplete, unsigned or undated, it will be returned to you for completion.**

#### Have you...

1. completed in full, signed and dated the Beneficiary's Statement?
2. completed the Beneficiary's Statement for each designated beneficiary?
3. had your Employer and/or Administrator complete, sign and date the Employer and/or Administrator's Statement, and had it sent to LifeMap with original enrollment forms and subsequent beneficiary changes?
4. Submitted the original certified Death Certificate, and, if applicable, police, accident and coroner reports?
5. if Policyholder is different than Employer, had Policyholder Statement on page 5 completed by Policyholder Representative?

#### Additional Instructions:

- If there is more than one beneficiary, all may submit information on one statement, or complete a separate Beneficiary's Statement for each beneficiary.
- If you assign a portion of the proceeds to a funeral home, please include the completed assignment form supplied by the funeral home. A separate check will be mailed direct to the funeral home.
- The death certificate of any deceased beneficiary must be provided.

**You are responsible for ensuring all forms are completed and returned to our office along with required documentation.**

Forms and documentation can be sent to LifeMap via:

\*Email: **claims@lifemapco.com**

\*Fax: **(855) 733-4615**

Regular Mail: **LifeMap Assurance Company  
Attn: Life and Disability Claims Department  
PO Box 1271 MS E8L  
Portland, OR 97207-1271**

\*If you are submitting claim via fax or email, you must also mail all original documents to the above address.

If you have any questions, please call the LifeMap Life and Disability Claims Department at (800) 286-1129.



Life Insurance Benefit Claim Form

Beneficiary's Statement

Information about Deceased

Name of Deceased (Last, First, Middle Initial)  <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Dependent Child	Date of Birth:	Date of Death:	Social Security Number:
Name of Member, if not the deceased (Last, First, Middle Initial)	Employer/Association:	Social Security Number:	

Medical Information

When did health of deceased first become impaired?	In last illness, when did deceased first consult physician?	Date deceased last attended full time work:
Place of death:	If hospital, hospice or institution, indicate date confinement began:	Date deceased last worked part-time:

Attending Physicians (List physicians who treated deceased immediately preceding death)

Physician Name:	Phone Number ( )	Condition(s):
Street Address      City      State      Zip	Fax Number ( )	Period of Treatment:
Physician Name:	Phone Number ( )	Condition(s):
Street Address      City      State      Zip	Fax Number ( )	Period of Treatment:

Additional Documentation (Please attach a copy of the following documents to this form.)

- Beneficiary Statement(s)
- Original certified Death Certificate (cause of death and manner of death must be determined)
- For Suicide, Homicide, Accidental Death Claims, please attach police, coroner, and toxicology reports

**Beneficiary Information and Acknowledgement** I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.

Beneficiary Name (Last, First, Middle Initial)	Social Security #	Mailing Address	City	State	Zip
Beneficiary Signature	Date Signed	Date of Birth	Phone Number	Relationship to Deceased	
Beneficiary Name (Last, First, Middle Initial)	Social Security #	Mailing Address	City	State	Zip
Beneficiary Signature	Date Signed	Date of Birth	Phone Number	Relationship to Deceased	
Beneficiary Name (Last, First, Middle Initial)	Social Security #	Mailing Address	City	State	Zip
Beneficiary Signature	Date Signed	Date of Birth	Phone Number	Relationship to Deceased	
Beneficiary Name (Last, First, Middle Initial)	Social Security #	Mailing Address	City	State	Zip
Beneficiary Signature	Date Signed	Date of Birth	Phone Number	Relationship to Deceased	

For additional beneficiaries, please complete and attach separate sheet.



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### Insurance Fraud Warning

**Unless specific state language is provided below, the following general fraud notice applies:** 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.

**California Residents:** 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 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.

**District of Columbia Residents:** 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.

**Florida Residents:** 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 containing any false or misleading information is guilty of a felony of the third degree.

**Hawaii Residents:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**New Jersey Residents:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York 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 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.

**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.

**Arkansas, Louisiana, Maryland, New Mexico, Rhode Island and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment for 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.

**Maine, Tennessee, Virginia and 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.

**Alaska, Kansas and Oregon Residents:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

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





P.O. Box 1271, M/S E8L  
Portland, OR 97207

LifeMap Assurance Company®

Life and Disability Claims Department  
Toll-free 1 (800) 286-1129  
Fax (855) 733-4615  
claims@lifemapco.com

Life Insurance Benefit Claim Form

LifeMapCo.com

**Policyholder's Statement**  
(Complete if Policyholder is different than Employer)

**Information about Deceased and Member**

Name of Deceased (Last, First, Middle Initial)  <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Dependent Child		Date of Birth	Date of Death	Social Security Number
Name of Member, if not the deceased (Last, First, Middle Initial)				Social Security Number
Employee's Effective Dates of Coverage with LifeMap: From: _____ Through: _____		Amount of Insurance Elected By Member:		
Employee's Premium Paid Through Date:		Basic Life: \$	Accidental Death: \$	
		Voluntary Life: \$	Dependent Life: \$	
		Other (specify): \$	Dependent Voluntary Life: \$	

**Information about Participating Employer**

Participating Employer Name			Employer's Effective Dates with LifeMap From: _____ Through: _____	
Employer's Eligibility Requirement (Hours Per Week)		Amount of Insurance Offered by Group:		
		Basic Life: \$	Accidental Death: \$	
Eligibility Waiting Period		Voluntary Life: \$	Dependent Life: \$	
		Other (specify): \$	Dependent Voluntary Life: \$	
Employer Address	Street & Number	City	State	Zip
				Phone Number ( )
Employer Representative Name			Email Address	

**Information about Policyholder**

Policyholder Name		Policyholder Effective Date		Policy Number	
Policyholder Address	Street & Number	City	State	Zip	Phone Number ( )
Name and title of Policyholder Representative completing this form				Email Address	

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 6 of this form.

▶ \_\_\_\_\_ ▶ \_\_\_\_\_  
Signature of Policyholder Representative Date



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