Combined Insurance Company of America

Claim Department • Administrative Office 17 Church St. Keene, NH 03431 Telephone 1-855-241-9891 Fax 603-357-0250

Claim Form for Life Insurance

Claim Number: _____

TO BE COMPLETED BY BENEFICIARY

DECEDENT INFORMATION

Deceased's Full Name		Policy Number	Form/Plan Number
Please list other names the deceased may have used such as maiden name, nickname, hyphenated name, alias, etc.		Policy Number	Form/Plan Number
Deceased's Address (Street and No.) City State Zip		Policy Number	Form/Plan Number
Deceased's Birth Date Mo Day Yr	Date of Death Mo. Day Yr	Policy Number	Form/Plan Number

If death was due to SICKNESS Please complete	Nature of sickness	
If death was due to ACCIDENT Please complete	Date of accident Mo. / Day / Year	Nature of injuries
	Please describe where and how accident occurred	

BENEFICIARY INFORMATION

Beneficiary's full name	Beneficiary's Birth Date: Mo. / Day / Yr	Relationship to deceased
Mailing Address (Street and No.) City State Zip		Home telephone # ( )
If beneficiary is a minor please list parent/guardian name and address		Work telephone # ( )
E-Mail Address		Cell telephone # ( )

FRAUD NOTIFICATIONS

If you are a resident of or if the policy was issued in one of the following states, we are required to provide you with the following Fraud Warning Notification:

ALABAMA: 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**.**

DISTRICT OF COLUMBIA: 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.

FLORIDA: Any person who knowingly and with the 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.

FRAUD NOTIFICATIONS CONTINUED

LOUISIANA: 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.

MARYLAND: 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.

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.

TENNESSEE: 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.

WASHINGTON: 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.

ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an enrollment form for insurance may be guilty of a criminal offense under state law.

REQUIRED SIGNATURE OF BENEFICIARY AND W-9 CERTIFICATION

By making claim to these proceeds, I declare that all the answers recorded on this Claim Form for Life Insurance are true and complete to the best of my knowledge and belief. I have read the applicable fraud notification statement. I also understand the Company reserves the right to require or obtain further information, should it be deemed necessary.

Substitute W-9

Under penalties of perjury, I certify that:

1. 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
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including U.S. resident alien).

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

Beneficiary's Signature		**Date**		**Social Security Number**						
Printed Name of Beneficiary				**Relationship***						

*If I signed on behalf of the beneficiary as the Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.

Please attach a certified copy of the insured's death certificate. If available, please also attach a copy of the obituary notice for the insured.