Phone: (877) 442-4207 | Fax: (855) 645-8242

## **EMPLOYER INFORMATION FOR SUBMITTING A LIFE CLAIM**

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## DearbornCares

## Advance Payment of the Life Insurance Benefit

DearbornCares provides an advance payment of up to \$10,000 per beneficiary in 48 hours\* to help cover their immediate expenses, such as funeral costs and medical bills.

- ▲ Pays up to \$10,000 per beneficiary of Employer-Paid Basic Life insurance claims
- ▲ Applies to claims with 1, 2 or 3 named beneficiaries
- ▲ Available for covered employees and retirees

#### The Death Certificate is NOT REQUIRED for the advance payment.

Please complete Part 1 of the Life Insurance Claim Form in its entirety and include the Beneficiary Designation. Any remaining information in the checklist below must be submitted to us in order to complete the claim and receive the full payment.

\*Pays up to \$10,000 per beneficiary (to max. of 3 beneficiaries) of Employer-Paid Basic Life insurance claims in 48 hours of confirming eligibility for DearbornCares. TPA Groups are not eligible for the DearbornCares program. This information is only a product highlight. DearbornCares has exclusions and limitations.

## **Employer Checklist for Submitting a Life Claim:**

The employer/administrator must complete the claim form as indicated and send attachments mentioned below. We will advise you if further documentation is necessary to complete the claim process.

Pleas	e submit the following documentation:
	Life Claim Form

- Part 1 Completed by the Employer/Administrator
- Part 2 Completed by the Beneficiary(ies)
- Part 3 Authorization for Release of Information to be completed by a beneficiary
- Enrollment Form, including any beneficiary changes (original, photocopy or screen print)
- **Certified copy of the Official Death Certificate** (for total coverages over \$100,000, we require an original Certified Death Certificate with a seal)
- Payroll Records verifying the insured's annual earnings at the time of death (if the benefits are based on salary)

If any portion of coverage is paid for by the insured, proof of payroll deduction.

# For Accidental Death Benefits, provide the following:

- Official, completed police report
- Proof of seat belt/airbag use, if applicable
- Newspaper clipping(s) of accident, if applicable
- Coroner's report, findings and/or toxicology report

#### Return completed form to: Blue Cross and Blue Shield of Texas (BCBSTX)

Attn: Life Claims Department • P.O. Box 7070 • Downers Grove, IL 60515

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Texas is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS<sup>®</sup>, BLUE SHIELD<sup>®</sup> and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.



## Life Insurance Claim Form

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## Part 1: To be completed by Employer/Administrator

Employer/Group	o Informati	on						
Group Name:		Group Number:						
Subsidiary Name:		Account Number/Division:						
Group Address:	Street:							
	City:			State:			Zip:	
Name and Title o	of Authorize	ed Representative:						
Phone:				Email:				
Preferred Comm	unication:	🗆 Email 🛛 Phone						
Employee Inform	nation							
Last Name:				First:			Middle:	
Street:							Birth Date:	
City:			State:		Zip:		Date of Deat	:h:
Phone:				Email:				
Employee SSN /	ID:			Status: I	□ Active	□ Retired	□ Disabled	□ Terminated
Date of Hire:		Insurance Effective Date	2:	Last Day	Worked:		Date Termin	ated:
Annual Salary: Class:		Salary Effective Date:						
Employee's Date of Last Premium Contribution:		Hours Worked per Week:						
Deceased Inform	nation (lf o	ther than employee)						
□ Spouse □	⊐ Depende	nt Child						
Last Name:				First:			Middle:	
Birth date:		Date of Death:		SSN:				
Full-Time Studen	t: 🗆 Yes	□ No		School:				
Was He/She Inca	pacitated a	and Reliant on the Emp	loyee for Fina	ancial Sup	port: 🗆 \	∕es □No		
			· .		_1			
Be	e sure to i	include the Benefic	liary Design	hation wi	nen sub	mitting the	e Claim For	m.
Insurance Inform	nation							
Basic Life: \$				AD&D:	5			

 Supplemental/Voluntary Life:
 \$

 Supplemental/Voluntary AD&D:
 \$

Additional Benefits:  $\Box$  Seat Belt  $\Box$  Airbag  $\Box$  Education  $\Box$  Other:

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Signature of Authorized Employer/Plan Representative

Date



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## Part 2: To be completed by Beneficiary

If there is more than one beneficiary, each must complete a separate form. See Important Information below if beneficiary is a minor.

Beneficiary Information				
Last Name:		First:		Middle:
Maiden Name:		Birth Date:	SSN / ID:	
Street:				
City:	State:	Zip:	Phone Numbe	r:
Email:		Relationship to Decease	ed:	
Deceased Information				
				N 41 1 1

Last Name:	First:	Middle:
SSN / ID:	Group Number/Name:	

#### **IRS** Certification

Are you a U.S. Citizen: Yes No, IRS Form W-8 is required. Provide other work ID if available.

#### Under penalty of perjury, I certify that:

- 1. The number shown on this form is my correct Social Security/Taxpayer Identification number; 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 notified me that I am no longer subject to backup withholding; and
- 3. I am a U.S. citizen or other U.S. person.

#### **Certification Instructions**

You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return.

The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. If you fail to certify, we may be required to withhold federal and state tax.

## Be sure to include a certified copy of the Death Certificate for claims over \$100,000.

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Signature of Beneficiary

Date

#### **IMPORTANT INFORMATION**

If the Beneficiary is:

- a. A minor, an estate or incompetent to handle financial matters: provide an original court order appointing a legal representative or guardian to handle the financial affairs of the minor, the estate, or the incompetent.
- b. Deceased: provide proof of death, a copy of the final certified death certificate, and documentation of the secondary beneficiary.
- c. A trust: provide documentation verifying existence of the trust, documentation that the trust has been named the beneficiary, and the tax identification number of the trust.

Each beneficiary must complete and sign the Beneficiary/Claimant Statement



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## Part 3: Authorization for Release of Information

(We will require a separate authorization for release of psychotherapy notes.)

I (the undersigned) authorize	physician, medical professional, pharmacist or other pro-
vider of health care services, hospital, clinic, other medical c	or medically related facility; coroner's office; insurance or reinsur-
ance company; government agency; department of labor; la	aw enforcement or public safety department; group policyholder;
employer; or policy or benefit plan administrator to release	information from the records of:

Deceased Last Name:	First:	Middle:
SSN / ID:	Group Number/Name:	

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Signature of Beneficiary	Date

#### IMPORTANT INFORMATION

- Claimant/Insured Information to be released:
- Data or records regarding medical history, treatment, prescriptions, consultations, autopsy (including medical reports, records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition(s));
- · Any information regarding insurance coverage; and
- Accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).
- Information to be released to: Blue Cross and Blue Shield of Texas P.O. Box 7070 Downers Grove, IL 60515
- I understand that refusal to sign this Authorization may result in the denial of benefits.
- I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

- I understand the information obtained by use of this Authorization will be used by BCBSTX (the Company) to evaluate my claim for death benefits. The Company will only release such information:
  - To its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
  - As may be required by law; or
  - As I further authorize.
- I understand that I may revoke this Authorization in writing at any time, except to the extent the Company has taken action in reliance on this Authorization. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signature below. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.
- A photocopy of this Authorization is to be considered as valid as the original.
- I understand I am entitled to receive a copy of this signed Authorization.

Signature (Claimant or Legal Representative)	Print Name	Date
If you are the legal representative of the Claimant, we	may ask for additional document	ation.
Street:		Phone Number:
City:	State:	Zip:

#### Fraud Notice: The laws of some states require us to furnish you with the following notice for claims only:

**Texas:** 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.