

# 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
<i>If death was due to SICKNESS Please complete</i>		Nature of sickness				
<i>If death was due to ACCIDENT Please complete</i>		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.

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**FRAUD NOTIFICATIONS CONTINUED**

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**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.

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**REQUIRED SIGNATURE OF BENEFICIARY AND W-9 CERTIFICATION**

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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.

<b>Substitute W-9</b>  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).
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**The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.**

  <b>Beneficiary's Signature</b>	  <b>Date</b>	<table border="1"><tr><td>  <b>Social Security Number</b></td></tr></table>	  <b>Social Security Number</b>
  <b>Social Security Number</b>			
  <b>Printed Name of Beneficiary</b>	  <b>Relationship*</b>		

\*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.**