



**GROUP LIFE CLAIM KIT
FOR PROCESSING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS
BY A THIRD PARTY ADMINISTRATOR**

INSTRUCTIONS FOR FILING A LIFE INSURANCE CLAIM

PLEASE SUBMIT THE FOLLOWING:

1. THE CLAIM FORM (PAGE 2) FULLY COMPLETED BY THE EMPLOYER AND THE NAMED BENEFICIARY AND SIGNED WHERE INDICATED.
2. A CERTIFIED COPY OF THE DEATH CERTIFICATE OF THE INSURED.
3. THE ORIGINAL ENROLLMENT CARD COMPLETED BY THE INSURED ON WHICH THE BENEFICIARY DESIGNATION HAS BEEN MADE AS WELL AS ANY CHANGE OF BENEFICIARY STATEMENTS. THE ORIGINAL FORMS MUST BE SUBMITTED. PHOTOCOPIES ARE NOT ACCEPTABLE.
4. IF CLAIM IS BEING MADE FOR ACCIDENTAL DEATH BENEFITS, THEN THE TOP PORTION OF PAGE 3 MUST ALSO BE FULLY COMPLETED BY THE NAMED BENEFICIARY. APPLICABLE POLICE REPORTS AND NEWSPAPER ARTICLES SHOULD ALSO BE ATTACHED.
5. THE BOTTOM PORTION OF PAGE 3 MUST BE FULLY COMPLETED BY THE THIRD PARTY ADMINISTRATOR FOR ALL CLAIMS BEING MADE.
6. HIPAA AUTHORIZATION FORM (PAGE 5) SHOULD BE FULLY COMPLETED BY THE NAMED BENEFICIARY OR NEXT OF KIN IF NAMED BENEFICIARY IS NOT NEXT OF KIN.

INSTRUCTIONS FOR FILING A DEPENDENT LIFE CLAIM

PLEASE SUBMIT THE FOLLOWING:

1. THE CLAIM FORM (PAGE 2) FULLY COMPLETED BY WHERE APPLICABLE FOR DEPENDENT COVERAGE, AND SIGNED BY THE EMPLOYER AND THE BENEFICIARY.
2. A CERTIFIED COPY OF THE DEATH CERTIFICATE OF THE DEPENDENT.
3. A PHOTOCOPY OF THE ORIGINAL ENROLLMENT FORM COMPLETED BY THE INSURED WHICH INDICATES THAT DEPENDENT COVERAGE HAS BEEN ELECTED.
4. THE BOTTOM PORTION OF PAGE 3 MUST BE FULLY COMPLETED BY THE THIRD PARTY ADMINISTRATOR FOR ALL CLAIMS BEING MADE.
5. HIPAA AUTHORIZATION FORM (PAGE 5) SHOULD BE FULLY COMPLETED BY THE NAMED BENEFICIARY OR NEXT OF KIN IF NAMED BENEFICIARY IS NOT NEXT OF KIN.

IF YOU SHOULD NEED ASSISTANCE IN THE COMPLETION OF THE CLAIM FORM
PLEASE CALL (781) 828-7000 EXT. 417

Please see Fraud Notice

CL 13 (W)
Rev 3/08
Expires 3/10

ACCIDENTAL DEATH CLAIM

Beneficiary must fully complete this section if claim Accidental Death Benefit.

Insured's Name: _____

Date and time of accident causing death:
 _____ 20__ _____ a.m. _____ p.m.

Place of death: Highway Home
 Work Recreation Other _____

Described Accident in detail (Please send copies of police reports, newspaper articles etc. to help in the processing of this claim)

Names of PHYSICIANS and HOSPITALS where Insured received treatment.

<u>Name</u>	<u>Address</u>
_____	_____
_____	_____
_____	_____

Was Autopsy Performed? Yes No If yes, by whom, where, and date.

<u>Name</u>	<u>Address</u>	<u>Date</u>
_____	_____	_____

ADMINISTRATOR'S STATEMENT

Name of Insured		Date of Death	Date of Birth
Name of Deceased Dependent (if applicable)		Date of Death	Date of Birth
Policy No	Social Security	Amount of Insurance being claimed \$ _____	Effective date of Insurance
Was Deceased's Insurance Subject to Medical Evidence of Insurability Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name of Employer		Address of Employer	
Full Name of Beneficiary	Beneficiary's Date of Birth	Relationship to Insured	

I hereby certify that the above named insured was covered under this policy and coverage was in force with premium paid as of the date of disability.

Signature and Address of Administrator

Address Where Check is to be Forwarded

_____	_____
_____	_____
_____	_____

Additional Beneficiary Statement
To be completed if there is more than one beneficiary

Name of Insured: _____

Policy #: _____

Beneficiary's Name _____

Beneficiary's Social Security No. _____

Beneficiary's Date of Birth _____

Beneficiary's Telephone No. _____

Beneficiary's Address: _____

Certification—Under the penalties of perjury, I certify that the information provided on this form is true, correct and complete.

X _____ / _____ / _____
Signature of Beneficiary Printed Signature Date

Beneficiary's Name _____

Beneficiary's Social Security No. _____

Beneficiary's Date of Birth _____

Beneficiary's Telephone No. _____

Beneficiary's Address: _____

Certification—Under the penalties of perjury, I certify that the information provided on this form is true, correct and complete.

X _____ / _____ / _____
Signature of Beneficiary Printed Signature Date

Beneficiary's Name _____

Beneficiary's Social Security No. _____

Beneficiary's Date of Birth _____

Beneficiary's Telephone No. _____

Beneficiary's Address: _____

Certification—Under the penalties of perjury, I certify that the information provided on this form is true, correct and complete.

X _____ / _____ / _____
Signature of Beneficiary Printed Signature Date

BOSTON MUTUAL LIFE INSURANCE COMPANY REQUIRED FRAUD NOTICES
For use with Claim Forms

STANDARD NOTICE:

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.

Notice to California residents:

For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to 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.

Notice to DC Residents:

Warning: It is a crime to provide false or misleading information to any 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 an applicant.

Notice to 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.

Notice to Maine 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 or a denial of insurance benefit.

Notice to 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.

Notice to New York Residents (Only applies to A&H):

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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Notice to Oklahoma Residents:

Any person who knowingly and with intent to injure, defraud or deceive any insurers, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Oregon Residents:

Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Notice to Puerto Rico Residents:

Any person who, knowingly and with the intent to defraud, presents false information in an insurance request for, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years, if mitigating circumstances prevail, it may be reduced to a minimum of two (2) years.

Notice to Virginia 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 may have violated state law.

Notice to 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.

Fraud Notice (rev. 3/25/08)
Expires 3/10