



**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-COMPLIANT AUTHORIZATION FORM 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-COMPLIANT AUTHORIZATION FORM 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 3/10  
Expires 3/13

**LIFE CLAIM FORM**

**Employer's Statement**

Name of Employee:		Name of Deceased Dependent (if applicable):	
Policy No:	Social Security No:	Birthdate of Employee or Dependent:	
Date Employee Enrolled for Insurance:		Date of Hire:	# of Hours worked:
Effective Date of Life Insurance Employee _____ Dependent _____	Amount of Insurance Basic _____ Supplemental _____		Dependent Coverage Spouse _____ Children _____
Was Employee at work on Effective Date? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was Insured Considered an Employee at date of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Annual Earnings \$ _____
Date of Death:	Date Last Worked:	Occupation:	
Reason for Employee leaving work: Disabled <input type="checkbox"/> Resigned <input type="checkbox"/> Temporary Lay-Off <input type="checkbox"/> Vacation <input type="checkbox"/> Retired <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Other _____			

I hereby certify that the above named deceased person was insured under the above policy and the coverage was in force with premium paid as of the date of death:

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Street City/Town State Zip

\_\_\_\_\_  
Area Code Telephone Ext.

**Beneficiary's Statement** (If more than one beneficiary, kindly attach an additional beneficiary statement)

Name of Beneficiary stated on Latest designation by Employer \_\_\_\_\_ Date of Birth \_\_\_\_\_ Beneficiary's Social Security No. \_\_\_\_\_ Relationship \_\_\_\_\_

Address of Beneficiary \_\_\_\_\_  
 Street City/Town State Zip

**Name and Address of all Physicians and Hospitals who treated insured in last 5 years.**

Name	Address	Dates Treated	Condition

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. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. **Please refer to "Fraud Warning Notices" insert for your state.**

X \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Signature of Insured Printed Signature Date

## 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>	Date
_____	_____	_____

### 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

_____	_____
_____	_____
_____	_____

Expires 3/13

**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 \_\_\_\_\_

Mailing Address, if different \_\_\_\_\_

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. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. **Please refer to "Fraud Warning Notices" insert for your state.**

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 \_\_\_\_\_

Mailing Address, if different \_\_\_\_\_

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. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. **Please refer to "Fraud Warning Notices" insert for your state.**

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 \_\_\_\_\_

Mailing Address, if different \_\_\_\_\_

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. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. **Please refer to "Fraud Warning Notices" insert for your state.**

X \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Signature of Beneficiary Printed Signature Date

## FRAUD WARNING NOTICES

For use with Claim Forms

### PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

**ALASKA:** A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**ARIZONA:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**ARKANSAS:** 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.

**CALIFORNIA:** For your protection California law requires the following to appear on this form:  
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.

**COLORADO:** 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.

**DELAWARE:** 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.

**DISTRICT OF COLUMBIA: 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:** 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.

**IDAHO:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**INDIANA:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing Any false, incomplete, or misleading information commits a felony.

**KENTUCKY:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**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.

**MAINE:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**MARYLAND:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**MINNESOTA:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**NEW HAMPSHIRE:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

## FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

### PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

**NEW MEXICO:** 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 CIVIL FINES AND CRIMINAL PENALTIES.

**NEW YORK:** 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.

**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.

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

**OREGON:** 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 may be guilty of insurance fraud.

**PENNSYLVANIA:** 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.

**PUERTO RICO:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**RHODE ISLAND:** 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.

**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.

**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.

**VIRGINIA:** 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.

**WEST VIRGINIA:** 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.

**ALL OTHER STATES:** 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 OF INFORMATION PRIVACY PRACTICES**

### **Boston Mutual Life Insurance Company (Herein referred to as “we”, “us”, “our”)**

Your privacy is important to us. We believe in ensuring the privacy of the information you give to us. This notice describes our privacy practices.

We restrict access to your non-public personal information (“*information*”) about you. We restrict it to those employees who have a need to know it. They need it to provide products and services to you. To protect your information, we maintain: physical; electronic; and procedural safeguards.

#### **COLLECTING INFORMATION**

We collect financial and health information about you in order to conduct business. Such uses are: to process requests for insurance products; to provide customer service; to process claims; to fulfill legal and regulatory requirements; and for other lawful purposes. We collect this information from you as well as from other sources.

Information we need to collect varies according to the products and services you request. It may include information from:

- your applications and other forms.
- other transactions you’ve had with us.
- consumer reporting agencies.
- your medical providers and health records.
- other sources.

#### **SHARING INFORMATION**

We treat the information we have collected about you in a confidential way. We do not disclose information about our customers or former customers to anyone, except as permitted or required by law.

We may share your information with third parties without your authorization as permitted by law. Such information is used to:

- process or service your insurance transactions with us.
- perform underwriting, administrative, account maintenance and claims functions.
- provide customer service or reinsurance coverage.
- protect against fraud.
- or perform other business functions on our behalf.

We may also share your information with:

- a consumer reporting agency in accordance with the Fair Credit Reporting Act.
- a third party to comply with federal, state or local laws, subpoenas or summonses.
- or as otherwise permitted or required by law.

Third parties receiving information from us are required to: keep it confidential; and to comply with all applicable federal and state privacy laws.

Information regarding your insurability will be treated as confidential. Boston Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formally known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (*TTY 866 346-3642*). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Boston Mutual Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

#### **ADVERSE UNDERWRITING DECISION**

You have the right to be advised in writing of the specific reasons for an adverse underwriting decision. Such decisions include:

- declining your application for insurance.
- offers to insure you at a higher than standard rate.
- termination of your coverage.

You must request this information in writing within 90 days from the date we mail you notice of the decision. We will furnish you with a statement of the specific reason for our decision within 21 days of receiving your written request for it.

#### **ACCESS TO YOUR PERSONAL INFORMATION WE HAVE IN OUR RECORDS**

You have the right to obtain access to all the information we have on you. You have the right to request: the amendment; correction; or deletion of such information. To do so, write us at the address below.

If you have questions about this notice or wish more information about our privacy policies, please write us at:

**Boston Mutual Life Insurance Company**  
Attention: Privacy Office  
120 Royall Street, Canton, MA 02021