UnitedHealthcare Speciality Benefits
PO Box 7149
Portland, ME 04112-7149
1-888-451-7986
Fax: 1-800-980-0298

United HealthCare Insurance Company
United HealthCare Insurance Company of Ohio
United HealthCare Insurance Company of Illinois

PROOF OF DEATH FOR GROUP INSURANCE

INSTRUCTIONS:
1. Claimant please fill in and sign section below.
2. Certified Death Certificate must be included in proofs.
3. Attach copy of police report, if accidental.
4. Attach copy of toxicology report if driver.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a notice of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

SECTION 1

CLAIMANT'S SIGNATURE

Deceased's Name	
Name of Insured Employee:	Deceased's S.S. Number
Deceased's Address	
Name of Employer	
Group Policy Number	
Deceased date of BIRTH	Deceased's date of DEATH
Place of death (if in hospital, give name and address of hospital)	
Cause of death	
Your Name	Your date of birth
Your Relationship to Deceased	Telephone Number
Your Address	

SIGNATURE AND SOCIAL SECURITY VERIFICATION
Please review the following statement and sign your name the way you would ordinarily sign a check. We are requesting your signature for two purposes: first, to certify your Social Security number; and second, to confirm your signature for the bank that will clear your checks.

Under the penalties of perjury, I certify that (1) the number I have documented on this form is my correct taxpayer identification number, and (2) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.

Social Security Number or Taxpayer Identification Number

Signature (IMPORTANT: Sign your name the way you would ordinarily sign a check) Date

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that by furnishing the form and investigating the claim, the United HealthCare Insurance Company shall not be held to admit validity of any claim, or waive any of its rights, or any of the conditions of the policy. I hereby authorize United HealthCare Insurance Company to obtain any medical or hospital records on the deceased. A photostat of this authorization will be as valid as the original authorization.

(OVER)

SECTION 2

STATEMENT OF EMPLOYER

We certify that, to the best of our knowledge and belief, the following statements and answers are true:

Full Name of Employee

Address of Employee	Street Address		
	City	State	Zip

Employer and Group Policy Number

Employee's Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date to which Employee's Individual Premiums are paid

Date of Employment

Date Deceased last present at work (Performing normal duties on full-time basis)

If Employee not actively at work on date of death, give reason:

☐ Discharged ☐ On Leave of Absence ☐ Quit ☐ On Vacation ☐ On Disability

☐ Temporary Work Stoppage

☐ Other, explain _____

Occupation or Class of Insured and scheduled hours worked

Basic Amount of Life Insurance $

Supplemental Life Insurance $

Name of Beneficiary*	Relationship

***Please attach any enrollment forms and beneficiary designations you retained.**

AUTHORIZED OFFICIAL MUST SIGN BELOW:

Name of Employer

Address of Employer

Telephone Number of Employer (with area code)

Signature of Employer