LifeMap® | P.O. Box 1271, M/S E8L
Portland, OR 97207

LifeMap Assurance Company®

Life and Disability Claims Department
Toll-free 1 (800) 286-1129
Fax (855) 733-4615
claims@lifemapco.com

LifeMapCo.com

Life Insurance Benefit Claim Form

Claim Filing Instructions

This Statement for Life Insurance Benefits includes the forms required to apply for Life Insurance benefits.
If a form is received incomplete, unsigned or undated, it will be returned to you for completion.

Have you…

1. completed in full, signed and dated the Beneficiary's Statement?
2. completed the Beneficiary's Statement for each designated beneficiary?
3. had your Employer and/or Administrator complete, sign and date the Employer and/or Administrator's Statement, and had it sent to LifeMap with original enrollment forms and subsequent beneficiary changes?
4. Submitted the original certified Death Certificate, and, if applicable, police, accident and coroner reports?
5. if Policyholder is different than Employer, had Policyholder Statement on page 5 completed by Policyholder Representative?

Additional Instructions:

- If there is more than one beneficiary, all may submit information on one statement, or complete a separate Beneficiary's Statement for each beneficiary.
- If you assign a portion of the proceeds to a funeral home, please include the completed assignment form supplied by the funeral home. A separate check will be mailed direct to the funeral home.
- The death certificate of any deceased beneficiary must be provided.

You are responsible for ensuring all forms are completed and returned to our office along with required documentation.

Forms and documentation can be sent to LifeMap via:

*Email: **claims@lifemapco.com**

*Fax: **(855) 733-4615**

Regular Mail: **LifeMap Assurance Company**
Attn: Life and Disability Claims Department
PO Box 1271 MS E8L
Portland, OR 97207-1271

*If you are submitting claim via fax or email, you must also mail all original documents to the above address.

If you have any questions, please call the LifeMap Life and Disability Claims Department at (800) 286-1129.

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Beneficiary's Statement

Information about Deceased

Name of Deceased (Last, First, Middle Initial) ◯ Member ◯ Spouse ◯ Domestic Partner ◯ Dependent Child	Date of Birth:	Date of Death:	Social Security Number:
Name of Member, if not the deceased (Last, First, Middle Initial)	Employer/Association:		Social Security Number:

Medical Information

When did health of deceased first become impaired?	In last illness, when did deceased first consult physician?	Date deceased last attended full time work:
Place of death:	If hospital, hospice or institution, indicate date confinement began:	Date deceased last worked part-time:

Attending Physicians (List physicians who treated deceased immediately preceding death)

Physician Name:				Phone Number ( )	Condition(s):
Street Address	City	State	Zip	Fax Number ( )	Period of Treatment:
Physician Name:				Phone Number ( )	Condition(s):
Street Address	City	State	Zip	Fax Number ( )	Period of Treatment:

Additional Documentation (Please attach a copy of the following documents to this form.)

- Beneficiary Statement(s)
- Original certified Death Certificate (cause of death and manner of death must be determined)
- For Suicide, Homicide, Accidental Death Claims, please attach police, coroner, and toxicology reports

Beneficiary Information and Acknowledgement I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.

Beneficiary Name (Last, First, Middle Initial)	Social Security #	Mailing Address	City	State	Zip
Beneficiary Signature	Date Signed	Date of Birth	Phone Number	Relationship to Deceased	
Beneficiary Name (Last, First, Middle Initial)	Social Security #	Mailing Address	City	State	Zip
Beneficiary Signature	Date Signed	Date of Birth	Phone Number	Relationship to Deceased	
Beneficiary Name (Last, First, Middle Initial)	Social Security #	Mailing Address	City	State	Zip
Beneficiary Signature	Date Signed	Date of Birth	Phone Number	Relationship to Deceased	
Beneficiary Name (Last, First, Middle Initial)	Social Security #	Mailing Address	City	State	Zip
Beneficiary Signature	Date Signed	Date of Birth	Phone Number	Relationship to Deceased	

For additional beneficiaries, please complete and attach separate sheet.

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Insurance Fraud Warning

Unless specific state language is provided below, the following general fraud notice applies: 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.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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 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.

District of Columbia Residents: 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 Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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.

New York 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 thereto, commits a fraudulent insurance act, which is a crime 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.

Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist, or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files, more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Arkansas, Louisiana, Maryland, New Mexico, Rhode Island and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment for 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, Tennessee, Virginia and 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.

Alaska, Kansas and Oregon Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

Delaware, Idaho, Indiana and Oklahoma Residents: 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.

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Life Insurance Benefit Claim Form

Employer's and/or Administrator's Statement

Information about Deceased and Member

Name of Deceased (Last, First, Middle Initial) ○ Member ○ Spouse ○ Domestic Partner ○ Dependent Child	Date of Birth	Date of Death	Social Security Number
Name of Member, if not the deceased (Last, First, Middle Initial)		Date of Birth	Social Security Number

Member Address Street & No.	City	State	Zip

Date of Membership/Employment:	Date Member Last Actively Worked: Full Time: Part Time:	Date of Employment Termination: ☐ N/A

Reason for member stopping work:	Amount of Insurance Claimed:	
○ Disability ○ Dismissed ○ Resigned ○ Layoff ○ Retired	Basic Life: $	Accidental Death: $
○ Family Medical Leave of Absence ○ Other Leave of Absence	Voluntary Life: $	Dependent Life: $
○ Other Reason:	Other (specify): $	Dependent Voluntary Life:$

Employee's Earnings $	Regular scheduled hours per week:	Occupation:
Date of last increase:	Earnings prior to increase: $	
☐ hourly ☐ weekly ☐ monthly ☐ annual ☐ commission ☐ shift differential ☐ bonuses ☐ other:		Last month premium was paid for member or dependent:

Information about Member's Coverage

Employee Life Insurance coverage:	Member also had the following coverage with LifeMap Assurance Company:
Effective Date of Coverage: Coverage Termination Date:	☐ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium

Beneficiary Information (Please have Beneficiary Statement form completed for each beneficiary)

Name of Beneficiary	Social Security Number	Relation	Date of Birth	Address	Phone

Additional Information

Additional Documentation (Please attach a copy of the following documents to this form.)

Original enrollment/beneficiary designation forms and all subsequent changes. If no original form ○ copy or scan of original ○ Electronically captured ○ Not on file

Information about Employer or Benefit Administrator

Employer or Association Name	Location/Class Code (if applicable)	Policy Number
Sevier County		WBT000977

Employer or Association Address Street & No.	City	State	Zip	Phone Number
250 N Main, Ste 116	Richfield	UT	84701	(435)893-0459

Name and title of Employer/Association Representative completing this form		Email Address
LeighAnn Wheeler	Human Resource Director	lawheeler@sevier.utah.gov

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 6 of this form.

▶ _____ ▶ _____

Signature of Employer/Association Representative — Date

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Policyholder's Statement

(Complete if Policyholder is different than Employer)

Information about Deceased and Member

Name of Deceased (Last, First, Middle Initial) ◯ Member ◯ Spouse ◯ Domestic Partner ◯ Dependent Child	Date of Birth	Date of Death	Social Security Number
Name of Member, if not the deceased (Last, First, Middle Initial)			Social Security Number

Employee's Effective Dates of Coverage with LifeMap: From: Through:	Amount of Insurance Elected By Member:	
	Basic Life: $	Accidental Death: $
Employee's Premium Paid Through Date:	Voluntary Life: $	Dependent Life: $
	Other (specify): $	Dependent Voluntary Life: $

Information about Participating Employer

Participating Employer Name		Employ**er**'s Effective Dates with LifeMap From: Through:
Employer's Eligibility Requirement (Hours Per Week)	Amount of Insurance Offered by Group:	
	Basic Life: $	Accidental Death: $
Eligibility Waiting Period	Voluntary Life: $	Dependent Life: $
	Other (specify): $	Dependent Voluntary Life: $
Employer Address Street & Number City State Zip		Phone Number ( )
Employer Representative Name		Email Address

Information about Policyholder

Policyholder Name	Policyholder Effective Date	Policy Number
Policyholder Address Street & Number City State Zip		Phone Number ( )
Name and title of Policyholder Representative completing this form		Email Address

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 6 of this form.

▶ _____ ▶ _____
Signature of Policyholder Representative Date

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