Proof of Death

Aetna International

Coverage underwritten by Aetna Life & Casualty (Bermuda) Ltd.

Group Life Insurance and Group Accidental Death Benefit Request

Please mail or fax this claim to:
Aetna Life Insurance
Attn: Veta Amos
151 Farmington Avenue, RT32
Hartford, CT USA 06156
Fax: 1-800-238-6239

A. Information About the Deceased

Deceased's Name (last, first, middle initial)			If deceased is known by any other name, provide Name (last, first, middle initial)		
Relationship to Employee	Social Security Number/I.D. Number	Birthdate (MM/DD/YYYY)	Date of Death (MM/DD/YYYY)	Age	Gender ☐ Male ☐ Female
Last Residence: Street		City	State/Country		ZIP/Postal Code

B. Information About the Employee

Employee's Name (last, first, middle initial)		Social Security Number/I.D. Number		Birthdate (MM/DD/YYYY)
Last Residence: Street		City	State/Country	ZIP/Postal Code
Date Employed (MM/DD/YYYY)	Employee's Work Location Name or Number		☐ Hourly ☐ Salary	Date Last Worked (MM/DD/YYYY)

Reason employee did not return to work after last day worked.
☐ Termination of Employment ☐ Disability ☐ Retirement ☐ Other (explain): ______

C. Information About the Employee's Coverage

Employer's Name		Representative's / Contact's Name / Email Address	
Street Address	City	State/Country	ZIP/Postal Code

Telephone Number (include area and/or country code)	Was an Accelerated Death Benefit, Accidental Dismemberment or Enhancement benefit such as Coma, Traumatic Brain Injury, Surgical Reattachment, Third Degree Burn, Children's Double Indemnity Benefit claim submitted prior to death? ☐ No ☐ Yes
Fax Number (include area and/or country code)	Was waiver of premium claim submitted prior to death? ☐ No ☐ Yes

Coverages for which benefits are in effect and being claimed

Coverages for which benefits are in effect and being claimed	Control	Suffix	Account	Plan	Effective date of employee's insurance (MM/DD/YYYY)	Amount of insurance in force as of the date last worked
☐ Term Life					/ /	
☐ ______					/ /	
☐ Supplemental					/ /	
☐ ______					/ /	
☐ Dependent					/ /	
☐ AD&D (AD&PL)					/ /	
☐ ______					/ /	
☐ ______					/ /	
☐ ______					/ /	
☐ ______					/ /	

If insurance is based on earnings, basic rate of earnings on date last worked or frozen salary
U.S. $ ______ per ☐ Hour ☐ Week, provide number of hours worked per week ______ ☐ Month ☐ Year

If insurance is based on other earnings, identify type (i.e., commission, bonus, etc.) and amount. Type ______ U.S. $ ______	Date of Last Salary Increase (MM/DD/YYYY)	Has amount of insurance increased (other than salary) within the last two years? ☐ No ☐ Yes If Yes, give date (MM/DD/YYYY) ______
Was employee required to submit evidence of insurability to secure current coverage? ☐ No ☐ Yes	Identify last period covered by employee or employer contributions/premiums.	If insurance is not in effect, give date discontinued (MM/DD/YYYY)

Has the deceased converted his group insurance? ☐ No ☐ Yes If Yes, give Policy Number ______	Did the deceased have an Aetna long term care policy? ☐ No ☐ Yes If Yes, give Policy Number ______

Please retain a copy for your records.

Deceased Information

Name (last, first, middle initial)
Social Security Number/I.D. Number

D. Information About The Beneficiary(ies)

	1.	2.	3.
Name (Full Name)			
Street			
City			
State/Country			
ZIP/Postal Code			
Social Security Number/I.D. Number			
Relationship to Employee			
Birthdate (MM/DD/YYYY)			
Telephone Number (include area and/or Country Codes):			
Home			
Work			

Has benefit/ownership been assigned? ☐ No ☐ Yes	If yes, to whom? (send copy of assignment)	Assignee's Social Security Number/ID Number

E. Summary of Reimbursement – Only one method of reimbursement and currency will be honored per payment.

(Unless otherwise indicated, reimbursements will be made via US$ check and payable to the party to which payment is sent.)

Requested Reimbursement Method: **(Check one)**	**Country/Currency Type for Reimbursement (i.e., Great Britain / Pounds) If the currency you've elected is not available for the method requested, we will default reimbursement to premium billing currency.**
☐ Checkbooks (Checkbooks will be mailed directly to the beneficiary) This will be the standard form of payment for all beneficiaries residing in the US. Beneficiaries whose state of residence does not allow checkbook payment will automatically receive a check.	
☐ Check (All beneficiary checks are mailed directly to the Plan Sponsor for distribution to the beneficiary) This option is available ***only*** to those beneficiaries residing outside the U.S. who do not elect the funds transfer option. Beneficiaries residing in the US whose state of residence does not allow payment in the form of a checkbook will automatically receive a check.	
☐ Funds Transfer (Preferred) (The most efficient method of transferring funds is via cross border or US ACH (wire transfer/electronic funds transfer). Please check with your bank to provide the information requested below.) This payment method is available ***only*** to beneficiaries residing outside the U.S. Payment will be made either in U.S. dollars or local currency upon request and where available.	

Bank Information:

Primary Bank – Required if wire transfer or EFT, as available, is your preferred reimbursement method as specified in Section D. (Aetna International can wire or EFT reimbursements to your bank at no cost. However, we encourage you to check with your bank to determine the fee your bank may charge you for these transaction(s).) Aetna International will transfer funds to your bank at no cost to you; however, we encourage you to check with your bank regarding any additional transaction fees.

Bank Account Number ______________________

Name of Accountholder *(As it appears on the Bank Statement)* ______________________

Bank Identification Code/Routing Number ______________________

☐ S.W.I.F.T./BIC Code (wire only) ☐ CHIPS UID ☐ Federal ABA ☐ Bank Sort ID ☐ IBAN ☐ Other ____________

Bank Name ______________________

Bank Address *(Include Country)* ______________________

Bank Telephone Number *(Include Country Code)* ______________________

Please retain a copy for your records.

Deceased Information

Name (last, first, middle initial)
Social Security Number/I.D. Number

F. Employer's Claim Submission Checklist Required Documents for all claims:

- ☐ Fully completed Proof of Death Claim form
- ☐ Insured's certified death certificate (*stating the cause of death)*
- ☐ Original and all the change of beneficiary designation forms
- ☐ Enrollment form or screen print confirming contributory coverage elections that were in-force on the day prior to the Aetna's plan effective date

G. Employer's Claim Submission Checklist Required Documents for Certain Claims:

The beneficiary provides the following information:

If the beneficiary is a minor child:
- ☐ A copy of the Birth certificate and Social Security Number
- ☐ Letters of Guardianship or Conservatorship of the estate of the minor child

If the beneficiary is the insured's estate:
- ☐ The letters of administration or letters of testamentary (Court Papers naming the Administrator or Executor of the Estate)

If the beneficiary is a trust:
- ☐ Provide copies of the Trust and letter of acceptance from the trustee with the Trust ID number

If a designated beneficiary has died:
- ☐ A copy of the beneficiary's death certificate

If no beneficiary was named or no beneficiary survives the insured and your policy provides for payment to next in line family member(s) submit:
- ☐ A notarized Aetna Affidavit of Sole Survivors completed by a family representative or

If no beneficiary was named or no beneficiary survives the insured and your policy provides for payment to the insured's estate:
- ☐ The letters of administration or letters of testamentary (Court Papers naming the Administrator or Executor of the Estate)

H. Employer's Claim Submission Checklist Required Documents for Accidental Death Claims:

The beneficiary provides the following if available:
- ☐ Police/accident report
- ☐ Autopsy report
- ☐ Toxicology report (not necessary if the deceased was a passenger in a motor vehicle accident)
- ☐ Any available newspaper articles concerning the accident

Complete the deceased name on the top of Page 2 and 3 before the Life insurance claim is faxed or mailed to our office. It is not necessary to follow-up with the original documents.

Fax to 1-800-238-6239 or Mail completed forms and other materials to:

Aetna Life Insurance
Attn: Veta Amos
151 Farmington Avenue, RT32
Hartford, CT USA 06156

If you have additional questions on the submission of this claim, please contact your Aetna International Account Representative.

Name ______________________________ Signature ______________________________

Date (MM/DD/YYYY) ______________ at (city, state, country, ZIP/postal code) ______________________________

Please retain a copy for your records.

I. Employer's Authorized Representative

Any person who knowingly and with intent to injure, defraud or deceive 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.

United States Fraud Statements Below:

Attention Alabama Residents: 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.

Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents: 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.

Attention California Residents: For your protection California law requires notice of 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.

Attention 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.

Attention 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.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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**.

Attention Louisiana Residents: 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 is guilty of a crime and may be subject to fines and confinement in prison.

Attention Maine and Tennessee 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 may include imprisonment, fines, or denial of insurance benefits.

Attention Maryland Residents: 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.

Attention Missouri 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, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Ohio Residents: 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.

Attention Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Pennsylvania 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 and subjects such person to criminal and civil penalties.

Attention 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.

Attention Texas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention 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.

Name ______________________ Signature ______________________

Date (MM/DD/YYYY) __________ at (city, state, country, ZIP/postal code) ______________________

Please retain a copy for your records.