Read "Notice" and "Instructions" on reverse side before completing this form.

Claim For Death Benefits Under Group Life Insurance

submitted to

Fort Dearborn Life Insurance Company

FORT DEARBORN LIFE INSURANCE COMPANY

(herein called the "Company")
Administrative Office: P.O. Box 655403, Dallas, Texas 75265-5403
1-800-778-2281

Having read and agreed to the notice and instructions printed on the reverse, I make the following statement in support of my claim to all or part of the proceeds, if any are payable, for the policy of insurance identified herein. Such information is submitted with the understanding that the Company may rely thereon, and represent and warrant to the Company that all statements and answers are true, correct, and complete.

Information About the Employee

Policy No. **GFZ39993** SSN _____ – _____ – _____

Employee Name _____ Employee's Date of Birth _____ /_____ /_____

Maiden Name if a married woman _____

Employee's Last Day at work or retirement date _____

Employee's Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Information About the Deceased

Full Name of Deceased _____ Date of Death ____ / ____ / ____

Deceased was: (Check One) _____Active Employee _____Retired Employee Sex _____

_____Active Dependent _____Retiree's Dependent

Deceased's Soc. Sec. No. _____–_____–_____ Date of Birth _____ /_____ /_____

Last place of employment _____ Occupation _____

Cause of death _____ If accident give details _____

_____

_____

Information About Claimant

Your Date of Birth_____ / _____ /_____

Full Name _____ Soc. Sec. No. _____–_____– _____

What was your relationship to the deceased at time of death_____

Name of other insurance companies under which you are claiming death benefits: _____

_____

The Claim is Being Made on Behalf of: (Check one)_____ Myself ____ The Estate of the Deceased ____ Other ____

If not in behalf of yourself, state the interest you represent, and the capacity in which you are acting _____

_____

Amount of benefit claimed $ _____

AGREEMENTS AND AUTHORIZATION:

I, the undersigned claimant, have read and agree that the above statements and answers are furnished in support of my claim for benefits and are complete, true and correctly recorded to the best of my knowledge and belief.

I understand and agree that:

- This authorization is voluntary but that my signature is required in order for Fort Dearborn Life Insurance Company (the "Company") to evaluate my claim for benefits;
- If I refuse to sign this authorization, the Company has the right to deny my claim, or that of my dependents, if applicable;
- I may revoke this authorization at any time in writing but that such a revocation will have no effect on any actions taken by the Company prior to receipt of the revocation;
- Information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by the Federal privacy laws;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy or facsimile of this authorization shall be as valid as the original;
- This authorization shall expire the later of 24 months from the date signed or at the end of any appeal processs concerning my claim.

I, as well as any person authorized to act on my behalf or my personal representative, acknowledge the right, upon request, to obtain a true copy of this authorization from the Company.

I authorize any employer and any medical professional, hospital, medical facility, medical provider, pharmacy, government agency, insurance carrier, HMO, MCO or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to the Company's claims department or its authorized representative(s) any information relating to the deceased concerning advice, care or treatment, including any claims processed by Blue Cross Blue Shield of Texas, for any health condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases.

I authorize any other person or authority who may have knowledge to provide the Company’s claims department or its authorized representative(s) all information and records with regard to any treatment, or conditions of the health of the deceased when such services were rendered or cause of death or other matters pertaining to the payment of the claim.

WARNING: 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.

Witness Signature _____ Signature of Claimant _____Date ___ / ___ / ___

Print Name _____ Print Name _____

Address _____ Address _____

City, State, ZIP Code _____ City, State, ZIP Code _____

Area Code & Telephone No. _____ Area Code & Telephone No. _____

Notice

The furnishing of this or any other form shall not constitute nor be considered an admission by the Company that there was any insurance in force on the life of the deceased, nor a waiver of any of its rights or defenses. The Company reserves the right to require, as Proofs of Loss, all documentary evidence, in addition to the items listed below, which it may reasonably deem necessary for determining the extent of its liability, if any, and the party or parties entitled to payment.

Any representative of the Company will gladly assist in completing Proofs of Loss, without charge. The Administrative Office will promptly reply to any inquiry with respect to the requirements for filing Proofs of Loss.

Instructions

1. A separate Claim for Death Benefits must be furnished by each person, or legal representative, asserting any claim under the policy.

2. A certified copy of the Death Certificate as officially filed must be submitted. If a death certificate can not be obtained, a Physician's Statement must be furnished, but only one such instrument need be furnished for all policies issued by the Company, and for all claimants under them.

3. If you are entitled to receive proceeds of $10,000 or more, you must complete a W-9 and submit it with your claim for Death benefits.

4. If the death is due to an accident or homicide, a newspaper clipping regarding the death should accompany the claim for Death Benefits, if available.

5. If a policy is payable to the estate of the insured or his executors or administrators, the Claim for Death Benefits must be signed and furnished by the executor or administrator of the estate, and certified Letters Testamentary or Letters of Administration issued by the court must be furnished. If a temporary administrator furnished a Claim for Death Benefits, it must be accompanied by a certified copy of the order of the court appointing such temporary administrator and expressly authorizing him to collect proceeds of the policy, and the court clerk's certificate on the order must also show that the temporary administrator has duly qualified and given bond and that the order has been recorded in the minutes of the court.

6. If a policy is payable to a minor or a person of unsound mind, the Claim for Death Benefits must be signed and furnished by the legal guardian of the estate of such person and certified Letters of Guardianship issued by the court must be furnished.

7. When a Claim for Death Benefits is made by a person claiming proceeds by virtue of the prior death of a designated beneficiary, a certified copy of the death certificate of the deceased beneficiary must be furnished.