



# Proof of Death

Group Life Insurance and Group Accidental Death Benefit Request  
(Filing instructions on reverse side)

Submit To:  
Aetna U.S. Healthcare  
Life Insurance Center  
151 Farmington Avenue  
Hartford, CT 06156-3007

### A. Information About the Deceased

Deceased's Name (last, first, middle initial) (1)		Relationship to Employee (2)	
Social Security Number (3)	Birthdate (4)	Date of Death (5)	Age (6)
Last Residence: Street (7)	City (7)	State (7)	Zip (7)

### B. Information About the Employee

Employee's Name (last, first, middle initial) (8)		Social Security Number (9)	Birthdate (10)
Date Employed (11)	<input type="checkbox"/> Hourly (12) <input type="checkbox"/> Salary	Date Last Worked (13)	Reason employee did not return to work after last day worked. (14)
Last Residence: Street (15)	City (15)	State (15)	Zip (15)

### C. Information About the Employee's Coverage

Employer's Name (16)		Representative's / Contact's Name (17)	
Street Address (18)		City (18)	State (18) Zip (18)
Telephone Number ( ) (19)	Was Accelerated death benefit claim submitted prior to death? <input type="checkbox"/> No <input type="checkbox"/> Yes (20)		Was waiver of Premium claim submitted prior to death? <input type="checkbox"/> No <input type="checkbox"/> Yes (21)

Coverages for which benefits are in effect, available or being claimed

Group Coverage	Control	Suffix	Account	Plan	Effective date of employee's insurance	Amount of insurance in force as of the date last worked
<input type="checkbox"/> Term Life	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Supplemental	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Dependent	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> AD&D	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Group Accident	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Paid-up	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Group Universal Life	_____	_____	_____	_____	_____	_____

If insurance is based on earnings, basic rate of earnings on date last worked, or frozen salary \$ _____ per <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		If insurance based on other than earnings, identify basis (i.e., job class, union, etc.)	
Date of Last Salary Increase	Has insurance percentage increased within the last two years? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, give date _____	Was employee required to submit evidence of insurability to secure current coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Identify last period covered by employee or employer contributions/premiums.	If insurance is not in effect, give date discontinued.	Was insured provided with a group conversion form?	

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Deceased Information

Name (last, first, middle initial) \_\_\_\_\_  
 Social Security Number \_\_\_\_\_

D. Information About The Beneficiary(ies)

	1.	2.	3.
Name	_____	_____	_____
Street	_____	_____	_____
City	_____	_____	_____
State/Zip	_____	_____	_____
Social Security Number	_____	_____	_____
Relationship to employee	_____	_____	_____
Birthdate	_____	_____	_____
Telephone number	_____	_____	_____
Home	(____) _____	(____) _____	(____) _____
Work	(____) _____	(____) _____	(____) _____

Has ownership been assigned?  No  Yes

If yes, to whom? (send copy of assignment) \_\_\_\_\_

Assignee's Social Security Number \_\_\_\_\_

E. Benefit Distribution Instructions

Return the benefit payment directly to:

Beneficiary  Beneficiary with copy to employer  Employer  Other \_\_\_\_\_

For information on settlement options or the Aetna Benefits Checkbook, please call 1-800-346-6538.

F. Employer's Instructions

- Please submit this form, with the following attachments to the Life Insurance Service Center as soon as possible.
- The insured's death certificate\*.
  - Original beneficiary designation and any or all change of beneficiary requests.
  - Enrollment forms (current and prior year).
  - If beneficiary(ies) are minor children:
    - a) Their birth certificates & Social Security numbers\*
    - b) Letters of Guardianship\* or conservatorship of the estate of the minor child\*
  - If beneficiary is the insured's estate:
    - a) The Letters of Administration or Letters of Testamentary.\*
  - If beneficiary is a trust:
    - a) Provide copies of trust and letter of acceptance from trustee with Trust ID number.
  - If designated beneficiary predeceased the employee:
    - a) A copy of the beneficiary's death certificate
    - b) Names, addresses, relationship of the employees next of kin, if the policy contains a next in line provision.
  - If Accidental Death benefits are being claimed, submit police/accident report with any available newspaper clippings and obituary notices concerning the accident.\*

Complete the deceased name on the top of Page 2 before the Life insurance claim is faxed to our office at 1-800-238-6239 or 1-800-AetnaFx. It is not necessary to follow-up with the original documents.

If you have any additional questions on the submission of this claim, please contact our office at 1-800-523-5065.

\* This information should be supplied by the beneficiary or the beneficiary's representative.

G. Employer's Authorized Representative

I certify that the above information is correct to the best of my knowledge. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be liable for substantial civil penalties.

Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ at (city, state, zip) \_\_\_\_\_