USAble Life℠

LIFE INSURANCE CLAIM FORM

SUBMIT YOUR CLAIM
Complete all fields and return to USAble Life
Attention: Claims Department
Mail: P.O. Box 1650 | Little Rock | AR | 72203
Email: claims@usablelife.com
Fax: (501) 235-8416
Online: USAbleLife.com/claims

CUSTOMER CARE
(800) 370-5856 Monday-Friday, 8 a.m. to 5 p.m. CST

CLAIM SUBMISSION CHECKLIST: Review and ensure you have all that is required for your claim to be processed.

ALL CLAIMS	ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) CLAIMS	CLAIMS NAMING MINORS AS THE BENEFICIARY	CLAIMS NAMING AN ESTATE AS THE BENEFICIARY	CLAIMS NAMING A TRUST AS THE BENEFICIARY
1. Claim Form 2. Fraud Notice 3. Employee Benefit Application 4. Beneficiary Designation(s) 5. Death Certificate (must contain original seal for claims exceeding $50,000)	Items 1-5 plus: • Police Report • Autopsy Report • Toxicology Report	Items 1-5 plus: • Letters of Guardianship • Beneficiary Birth Certificate • Beneficiary Social Security Card	Items 1-5 plus: • Letters of Administration or Testamentary	Items 1-5 plus: • Copies of Trust and Letters of Acceptance from the Trustee with the Trust ID Number

SECTION 1: EMPLOYEE INFORMATION

Policyholder Name (last, first, middle)		Date of Birth
Address (street, city, state, and ZIP)		
Telephone No.	Social Security No.	Gender ☐ Male ☐ Female
Date of Loss (AD&D claims require both police and toxicology reports)		

SECTION 2: DEPENDENT INFORMATION

Insured Name (last, first, middle)		Date of Birth
Address (street, city, state, and ZIP)		
Telephone No.	Social Security No.	Gender ☐ Male ☐ Female
Relationship to Employee ☐ Self ☐ Spouse ☐ Dependent		
Date of Loss (AD&D claims require both police and toxicology reports)		

SECTION 3: EMPLOYER'S STATEMENT

Employer Name		Group Policy No.
Contact Name and Title		
Address (street, city, state, and ZIP)		
Telephone No.	Fax No.	Email Address
Employee's Hire Date	Date Employee Last Worked	Employee's Hours Worked (per week)
Employee's Occupation at Time of Leave		

Insured Employee Benefits **(provide amount for each benefit enrolled)**		Reason for Employee's Leave **(provide date if it is different from the date employee last worked provided above)**		Did the employee designate a beneficiary? ☐ Yes ☐ No **(if yes, submit a copy of the designation with the claim)**	
☐ Group Term Life (GTL)	$				
☐ Voluntary Group Term Life (VGTL)	$				
☐ Supplemental Group Term Life	$	☐ Death	Date	☐ Spouse	☐ Other
☐ Dependent Term Life	$	☐ Disability	Date	☐ Trust	
☐ Group AD&D	$	☐ Retirement	Date	☐ Minor	
☐ Voluntary AD&D	$	☐ Termination	Date	☐ Estate	

Are premiums paid to-date for this employee? ☐ Yes ☐ No **(if no, provide date premiums discontinued)**		Date
Is benefit based on salary multiple? ☐ Yes ☐ No **(if yes, provide salary information)**	Salary	Effective Date
Signature of Contact		Date

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SECTION 4: BENEFICIARY STATEMENT

Beneficiary Full Name (last, first, middle)		Date of Birth
Address (street, city, state, and ZIP)		Telephone No.
Fax No.	Social Security No.	Email Address
Gender ☐ Male ☐ Female	Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent	
Signature of Beneficiary		Date
I attest to the fact that the information provided is to the best of my knowledge, complete and accurate.		

Beneficiary Full Name (last, first, middle)		Date of Birth
Address (street, city, state, and ZIP)		Telephone No.
Fax No.	Social Security No.	Email Address
Gender ☐ Male ☐ Female	Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent	
Signature of Beneficiary		Date
I attest to the fact that the information provided is to the best of my knowledge, complete and accurate.		

Beneficiary Full Name (last, first, middle)		Date of Birth
Address (street, city, state, and ZIP)		Telephone No.
Fax No.	Social Security No.	Email Address
Gender ☐ Male ☐ Female	Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent	
Signature of Beneficiary		Date
I attest to the fact that the information provided is to the best of my knowledge, complete and accurate.		

Beneficiary Full Name (last, first, middle)		Date of Birth
Address (street, city, state, and ZIP)		Telephone No.
Fax No.	Social Security No.	Email Address
Gender ☐ Male ☐ Female	Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent	
Signature of Beneficiary		Date
I attest to the fact that the information provided is to the best of my knowledge, complete and accurate.		

Beneficiary Full Name (last, first, middle)		Date of Birth
Address (street, city, state, and ZIP)		Telephone No.
Fax No.	Social Security No.	Email Address
Gender ☐ Male ☐ Female	Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent	
Signature of Beneficiary		Date
I attest to the fact that the information provided is to the best of my knowledge, complete and accurate.		

FRAUD WARNING: Except as noted in the separate Fraud Notice, 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.

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FRAUD NOTICE

FOR YOUR PROTECTION, THE LAWS OF SOME STATES MAY REQUIRE US TO FURNISH YOU WITH THE FOLLOWING NOTICE: 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. Please see below for special notices required by state law for residents.

AL	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.
AK	Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
AZ	Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
CA	For your protection, California law requires 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.
CO	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.
DE, ID, IN	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.
DC	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.
FL	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 of the third degree.
KS	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 may be guilty of a crime and subject to fines and confinement in prison as determined by a court of law.
KY	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.
ME, TN	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, and denial of insurance benefits.
MD, RI, TX	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.
MN	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
NH	Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
NJ	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
NM	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 civil fines and criminal penalties.
OH	Any person who, with the 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.
OK	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.
OR	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 may be guilty of a crime and subject to fines and confinement in prison.
PA	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.
VT	Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
VA,WA	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.

SIGN AND DATE BELOW (I have read and understand the Fraud Warning that applies to my state of residence.)

Name (last, first, middle)	Telephone No.
Signature	Date

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AUTHORIZATION TO DISCLOSE, OBTAIN, AND USE PERSONAL INFORMATION

In signing below, I represent the statements I may have provided for claim review are true, complete and correct. I hereby authorize third persons, including, without limitation: any financial institution, consumer reporting agency, insurance company or reinsurer, insurance service organization such as the MIB, Inc., benefit plan administrator, health plan, hospital, health care provider, pharmacy, laboratory, business associate, governmental entity (federal, state, or local), or any other organization or individual (collectively "Third Parties"); to disclose the minimum necessary personal, financial and health information, including physical, psychological, psychiatric, drug or substance use and communicable disease diagnosis or treatment information ("Personal Information") to USAble Life (the "Company"), its representatives or agents in connection with underwriting, claim evaluation or processing, medical or disability assessment and management, or treatment, payment, and operations related activities (the "Permitted Activities"). The Company may possess and further disclose Personal Information obtained from me, Third Parties, or developed by the Company to other Third Parties, claim or medical management organizations, investigative firms, agents, employees, consultants, and others who have a legitimate business interest in obtaining the minimum necessary Personal Information in connection with the Permitted Activities. If any provision of this authorization is or becomes invalid or unenforceable pursuant to applicable Federal or State laws, it shall be ineffective only to the extent of such invalidity or unenforceability, and the remaining provisions of this authorization shall not be affected. This authorization is valid for the lesser of: the period that my coverage from the Company remains in effect or; if this authorization is given in connection with the Company's consideration of a claim for benefits, for the duration of the Company's consideration of that claim. I have the right to revoke this authorization, in writing, at any time or to refuse to sign this authorization. I acknowledge that if I do so, that revocation may adversely affect the completion of the Permitted Activities, including the denial of a claim for benefits. Any written revocation of this authorization shall become effective upon receipt by the Company, but shall not apply retroactively as to Personal Information that has been previously disclosed, obtained, or used in accordance with this authorization. A photocopy of this form is as valid as the original. A copy of this authorization will be provided to me or my authorized representative upon request.

Name (last, first, middle)	
Telephone No.	Email Address
Signature	Date