CareAmerica
Life Insurance Company

P.O. Box 7725, San Francisco, CA 94120
1-888-646-0789

PROOF OF DEATH
FOR CAREAMERICA LIFE INSURANCE COMPANY (CAREAMERICA LIFE)

NOTE: Please complete the entire claim form. This form cannot be processed if information is incomplete.

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

SECTION 1

NAME OF DECEASED	SOCIAL SECURITY NO.	DATE OF BIRTH
IF DEPENDENT CLAIM, NAME, SOCIAL SECURITY NO. OF EMPLOYEE	DATE OF DEATH	
AMOUNT OF INSURANCE BEING CLAIMED (specify amounts claimed for Life, AD&D, Supplemental, etc.) ☐ Life __________ ☐ AD&D __________ ☐ Supplemental __________	GROUP POLICY NO.	EFFECTIVE DATE OF EMPLOYEE'S INSURANCE
JOB CLASSIFICATION OF EMPLOYEE	MONTHLY OR ANNUAL SALARY (exclusive of overtime, bonuses, and other extra compensation) ☐ Monthly __________ ☐ Annual __________	
DATE OF EMPLOYEES EMPLOYMENT OR DATE OF UNION/ASSOCIATION MEMBERSHIP:	LAST MONTH FOR WHICH PREMIUM WAS PAID FOR THIS EMPLOYEE OR DEPENDENT:	DATE EMPLOYEE LAST REPORTED FOR WORK:
REASON FOR EMPLOYEE STOPPING WORK		
WAS LIFE INSURANCE IN FORCE AT DATE OF DEATH? ☐ Yes ☐ No If not in force, date discontinued:	DID THE EMPLOYEE HAVE A WAIVER OF PREMIUM (Continued Life Insurance) CLAIM WITH CAREAMERICA LIFE? ☐ Yes ☐ No	
DATE OF LAST SALARY INCREASE	AVERAGE HOURS WORKED	AMOUNT OF MONTHLY PREMIUM PAID

SECTION 2 – BENEFICIARIES

NAME	SOCIAL SECURITY NO.			DATE OF BIRTH	% OF BENEFITS
ADDRESS (NUMBER, STREET, APARTMENT)	CITY	STATE	ZIP	TELEPHONE NO.	
NAME	SOCIAL SECURITY NO.			DATE OF BIRTH	% OF BENEFITS
ADDRESS (NUMBER, STREET, APARTMENT)	CITY	STATE	ZIP	TELEPHONE NO.	
NAME	SOCIAL SECURITY NO.			DATE OF BIRTH	% OF BENEFITS
ADDRESS (NUMBER, STREET, APARTMENT)	CITY	STATE	ZIP	TELEPHONE NO.	

SECTION 3 – SIGNATURES

Remarks:____

____

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

DATED______________________, 20________ POLICY (GROUP) NAME ______________________

IMPORTANT NOTICE: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of loss is guilty of a crime and may be subject to fines and confinement in state a prison.

FORMS TO BE ATTACHED:

1. Original Enrollment Cards, and Change of Beneficiary Cards (Be sure to include all which pertain to this insurance.) (If dependent claim, enrollment card will be returned after a determination has been made on the claim.)
2. Certified Death Certificate (has the seal of the Health Department pressed into the paper, stamped in colored ink, or is printed on colored paper)
3. Photocopy of Dues Record if Union
4. Deceased's insurance Certificate (if available)
5. For AD&D and Seat Belt claims, newspaper clippings, police and accident reports, or other information (if available) regarding the accident.

By ______________________
(Signature of Administrator of Group)

____
(Please Print Administrator's Name)

____
Area Code Phone Number

____
Address

SPECIAL INSTRUCTIONS

1. All Death Claims MUST be accompanied by an original CERTIFIED DEATH CERTIFICATE listing manner and cause of death. A copy of a Certified Death Certificate CANNOT be accepted.
2. If death resulted from anything OTHER THAN Natural Causes (i.e. accident, homicide), a copy of the OFFICIAL investigative report (i.e. police, accident, fire, FAA, OSHA) must accompany or follow the claim. AD&D benefits cannot be paid on any claim without an investigative report regarding the Insured Person's/Dependent's death. If your Group Contract contains an Alcohol Drug Exclusion, a Toxicology Report will be required.
3. Groups MUST submit the enrollment form and copies of any beneficiary changes. if a beneficiary cannot be identified, benefits for the death of an Insured person will be paid to his or her Estate.

IF PRIMARY BENEFICIARY HAS DIED

4. If the Primary Beneficiary is no longer living – a copy of the Certified Death Certificate must accompany the claim before payment can be made to the Contingent (secondary) Beneficiary or to the Estate. If the Contingent (secondary) Beneficiary is also deceased, a copy of that Certified Death Certificate will also be required.

IF THERE IS NO BENEFICIARY

5. If no beneficiary is named, or if no beneficiary survives the Insured Person – payment will be made to the Insured Person's Estate unless a Preference Beneficiary Affidavit is completed.

IF PAYMENT IS TO BE MADE TO AN ESTATE

6. Court documents of appointment must be forwarded to CareAmerica Life Insurance Company before payment can be made to the Estate. The Court documents must name the personal Representative of the Estate (called the Executor, Executrix, Administrator or other Court designated title) to whom benefits can be paid.

IF PAYMENT IS MADE TO A TRUST

7. If payment is to be made to a Trust, a copy of the Trust Document must be provided with the claim. Such documents should designate the Trustee to whom proceeds will be paid.

IF BENEFICIARY IS A MINOR CHILD

8. A Minor lacks capacity to sign a binding release of an insurance contract. Only the lawfully appointed guardian/representative of a Minor may give release for the payment to a Minor. Life Insurance Benefits, therefore, cannot be paid to anyone who has not reached the age of majority. If Guardianship documents are not secured, the proceeds will be held until the beneficiary reaches he age of majority, unless State Statutes (i.e. the Uniform Gifts/Transfers to Minors Act) in the appropriate jurisdiction allow for other payment provisions to be used. Copies of such applicable Statutes should accompany the claim.