Dearborn National®
Life Insurance Company of New York

Phone Number: (800) 778-2281
Fax: (312) 540-4706

Death Claim Form
Return to Dearborn National NY at:
Attention: Claims Department
1020 31st Street
Downers Grove, IL 60515-5591

Employee/Member Name	SSN	Group #	Claimant Phone #

INSTRUCTIONS
The employer/administrator must complete the claim form as indicated and send attachments mentioned below. We will advise you if further documentation is necessary to complete the claim process.

Please submit the following documentation:

1. Death Claim Form:
   Part 1 – Completed by the Employer/Administrator
   Part 2 - Completed by the Beneficiary(ies)

2. Original, photocopy or screen print of enrollment form, including any beneficiary changes.

3. A certified copy of the official death certificate.

4. If the benefits are based on salary, payroll records verifying the insured's annual earnings at the time of death.

5. If any portion of coverage is paid for by the insured, proof of payroll deduction.

6. For accidental death benefits, provide the following:
   a. Official completed police report
   b. Proof of seatbelt/airbag use if applicable
   c. Newspaper clipping(s) of accident, if applicable
   d. Coroner's report, findings and/or toxicology report

7. If the Beneficiary is:

   a. A minor, an estate or incompetent to handle financial matters: provide an original court order appointing a legal representative or guardian to handle the financial affairs of the minor, the estate, or the incompetent.
   b. Deceased: provide proof of death, a copy of the final certified death certificate, and documentation of the secondary beneficiary.
   c. A trust: provide documentation verifying existence of the trust, documentation that the trust has been named the beneficiary, and the tax identification number of the trust.

8. Each beneficiary must complete and sign the Beneficiary/Claimant Statement.

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Part 1 – To be completed by Employer/Administrator Statement of Employer

Employer/Plan Information

Group Name _____ Subsidiary Name _____

Group Number _____ Account#/Division# _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Authorized Representive _____ (Last) _____ (First) _____ (Middle) _____ (Title)

Phone Number _____ Fax Number _____

E-mail Address _____

Preferred communication: ☐ e-mail ☐ phone ☐ fax

Deceased Person Information (include Certified Copy of Death Certificate)

Name _____ (Last) _____ (First) _____ (Middle) _____ (Relation to Employee/Member) _____ (Date of Death)

Insured Information

Name _____ (Last) _____ (First) _____ (Middle) Social Security No. _____

Class _____ DOB _____ Hire Date _____ Occupation _____

Insurance Effective Date or Credits accumlted _____ Date of Last Premium Contribution _____

Annual Salary _____ Date of Last Salary Increase _____ Work Schedule _____ hrs/wk
(If salary based benefit or if any portion of premium is contributory please submit proof of payroll deduction)

Last Day Worked _____ Reason for Stopping Work _____
(resignation, disability, retirement, illness, layoff, leave of absence, vacation, other - please list)

If Retired, Date of Retirement _____
If Terminated, Date of Termination _____
If Disabled, Date of Disability _____

Waiver of Premium: ☐ Yes ☐ No Continuation of Life Insurance: ☐ Yes ☐ No Extended Life: ☐ Yes ☐ No

Beneficiary(ies) (include address and phone #) _____

Online Beneficiary Tracking: ☐ Yes ☐ No Tracking System _____

Coverages:
Amount of Insurance

Basic Life		Additional Benefits	Seat Belt
Supplemental Life			Air Bag
AD&D			Critical Illness
Voluntary Life			Education
Dependent Life			Other

If Deceased is a Dependent Child, Please Complete the Following

Dependent Child's Date of Birth _____ Full-Time Student: ☐ Yes ☐ No School _____

Is He/She Incapacitated and Reliant on the Employee for Financial Support: ☐ Yes ☐ No

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

Signature of Authorized Employer/Plan Representative _____

Print Name _____ Date _____

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Part 2 – To be completed by Beneficiary
***If there is more than one beneficiary, each must complete a separate form. See Instruction page If beneficiary is a minor.**

Name _____ (Last) _____ (First) _____ (Middle)

Date of Birth _____ Social Security No. _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Phone Number _____ E-mail _____

Relationship to Deceased _____ Comments _____

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

Signature of Beneficiary _____

Print Name _____ Date _____

IRS Certification

Are you a U.S. Citizen: ☐ Yes ☐ No

(If No – IRS Form W-8 required) Provide other work ID if available _____

Under penalty of perjury, I certify that:

1. The number shown on this form is my correct Social Security/Taxpayer Identification number; and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person.

NOTE: Certification Instructions – You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. If you fail to certify, we may be required to withhold federal and state tax.

Your Signature _____

Print Name _____ Date _____

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AUTHORIZATION FOR RELEASE OF INFORMATION (We will require a separate authorization for release of psychotherapy notes.)

I (the undersigned) authorize _____ physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; coroner's office; insurance or reinsurance company; government agency; department of labor; law enforcement or public safety department; group policyholder; employer; or policy or benefit plan administrator) to release information from the records of:

Deceased's Name _____ (Last) _____ (First) _____ (Middle)

Claimant/Insured Information to be released:

- Data or records regarding medical history, treatment, prescriptions, consultations, autopsy (including medical reports; records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition(s));
- Any information regarding insurance coverage; and
- Accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).
- Information to be released to: Dearborn National NY
  1020 31st Street
  Downers Grove, IL 60515

- I understand the information obtained by use of this Authorization will be used by Dearborn National Life Insurance Company of New York (the Company) to evaluate my claim for death benefits. The Company will only release such information:
  - To its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
  - As may be required by law; or
  - As I further authorize.
- I further understand that refusal to sign this Authorization may result in the denial of benefits.
- I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- I understand that I may revoke this Authorization in writing at any time, except to the extent the Company has taken action in reliance on this Authorization. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signature below. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.
- A photocopy of this Authorization is to be considered as valid as the original.
- I understand I am entitled to receive a copy of this signed Authorization.

Signature (Claimant or Representive) _____

Print Name _____ Date _____

Relationship to Claimant or Description of Authority to Act if
You are the Personal or Legal Representative of the Claimant _____

If you are the legal representative of the Claimant we may ask for additional documentation.

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Phone Number _____

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