



LIFE INSURANCE CLAIM FORM

SUBMIT YOUR CLAIM

Complete all fields and return to US Able Life

Attention: Claims Department

Mail: P.O. Box 1650 | Little Rock | AR | 72203

Email: claims@usablelife.com

Fax: (501) 235-8416

Online: US AbleLife.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

1. Claim Form
2. Fraud Notice
3. Employee Benefit Application
4. Beneficiary Designation(s)
5. Death Certificate (must contain original seal for claims exceeding \$100,000)

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) CLAIMS

Items 1-5 plus:

- Police Report
- Autopsy Report
- Toxicology Report

CLAIMS NAMING MINORS AS THE BENEFICIARY

Items 1-5 plus:

- Letters of Guardianship
- Beneficiary Birth Certificate
- Beneficiary Social Security Card

CLAIMS NAMING AN ESTATE AS THE BENEFICIARY

Items 1-5 plus:

- Letters of Administration or Testamentary

CLAIMS NAMING A TRUST AS THE BENEFICIARY

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 <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, submit a copy of the designation with the claim) | |
| <input type="checkbox"/> Group Term Life (GTL) | \$ | | | |
| <input type="checkbox"/> Voluntary Group Term Life (VGTL) | \$ | | | |
| <input type="checkbox"/> Supplemental Group Term Life | \$ | | | |
| <input type="checkbox"/> Dependent Term Life | \$ | | | |
| <input type="checkbox"/> Group AD&D | \$ | | | |
| <input type="checkbox"/> Voluntary AD&D | \$ | <input type="checkbox"/> Death | Date | <input type="checkbox"/> Spouse <input type="checkbox"/> Other |
| | | <input type="checkbox"/> Disability | Date | <input type="checkbox"/> Trust |
| | | <input type="checkbox"/> Retirement | Date | <input type="checkbox"/> Minor |
| | | <input type="checkbox"/> Termination | Date | <input type="checkbox"/> Estate |
| Are premiums paid to-date for this employee? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, provide date premiums discontinued) | | | Date | |
| Is benefit based on salary multiple? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, provide salary information) | | | Salary | Effective Date |
| Signature of Contact | | | Date | |



LIFE INSURANCE CLAIM FORM

SUBMIT YOUR CLAIM

Complete all fields and return to US Able 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

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.



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 | For your protection Arizona law requires the following statement to appear on this form: 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 | 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 or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. |
| ID | Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. |
| IN | A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. (27.2.16.3) |
| KS | 40-2,118. Fraudulent insurance act defined; amount involved defined; penalty; notification of commissioner, when; antifraud plan. (a) For purposes of this act a "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance that such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto. |
| 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 | 24-A2186(3) 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 or a denial of insurance benefits. |

| | |
|-----------|---|
| MD | 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 | 365:10-1-11 WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an 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. |
| RI | 27-29-13.3 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. |
| TN | 56-53-106 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. |
| TX | 704.002 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. |
| VA | 2-40 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. |
| 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. |
| 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 Notice that applies to my state of residence.)

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

US Able LifeSM is used with the consent of US Able Mutual Insurance Company.

© 2024 Life & Specialty Ventures, L.L.C. All rights reserved.



USABLE LIFE
Mail: P.O. Box 1650 | Little Rock | AR | 72203
Email: claims@usablelife.com
Fax: (501) 235-8416

**AUTHORIZATION TO DISCLOSE, OBTAIN,
AND USE PERSONAL INFORMATION**

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

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