



P.O. Box 1271, M/S E3A
Portland, OR 97207

LifeMap Assurance Company™

Life and Disability Claims Department
Toll-free 1 (800) 286-1129
Fax (855) 733-4615
claims@lifemapco.com

LifeMapCo.com

Life Insurance Benefit Claim Form

Claim Filing Instructions

This Statement for Life Insurance Benefits includes the forms required to apply for Life Insurance benefits. **If a form is received incomplete, unsigned, or undated, it will be returned to you for completion.**

Have you...

1. completed in full, signed, and dated the Beneficiary's Statement?
2. completed the Beneficiary's Statement for each designated beneficiary?
3. had your Employer and/or Administrator complete, sign, and date the Employer and/or Administrator's Statement, and had it sent to LifeMap with original enrollment and beneficiary designation forms and any subsequent beneficiary changes?
4. submitted the original certified Death Certificate with cause and manner of death and, if applicable, police, accident and coroner reports?
5. if Policyholder is different than Employer, had Policyholder Statement on page 5 completed by Policyholder Representative?

Additional Instructions:

- If there is more than one beneficiary, all may submit information on one statement, or complete a separate Beneficiary's Statement for each beneficiary.
- If you assign a portion of the proceeds to a funeral home, please include the completed assignment form supplied by the funeral home. A separate check will be mailed direct to the funeral home.
- The death certificate of any deceased beneficiary must be provided.

You are responsible for ensuring all forms are completed and returned to our office along with required documentation.

Forms and documentation can be sent to LifeMap via:

*Email: **claims@lifemapco.com**

*Fax: **(855) 733-4615**

Regular Mail: **LifeMap Assurance Company
Attn: Life and Disability Claims Department
PO Box 1271 MS E3A
Portland, OR 97207-1271**

*If you are submitting claim via fax or email, you must also mail all original documents to the above address.

If you have any questions, please call the LifeMap Life and Disability Claims Department at (800) 286-1129.



Life Insurance Benefit Claim Form

Beneficiary's Statement

Information about Deceased

Name of Deceased: (Last, First, Middle Initial) <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Dependent Child		Date of Birth:	Date of Death:	Social Security Number:
Name of Member, if not the deceased:	Date of Birth:	Employer/Association: Cassia Jt School Dist151	Social Security Number:	

Medical Information

When did health of deceased first become impaired?	In last illness, when did deceased first consult physician?	Date deceased last attended full time work:
Place of death:	If hospital, hospice or institution, date confinement began:	Date deceased last worked part-time:

Attending Physicians (List physicians who treated deceased immediately preceding death)

Physician Name:	Phone Number ()	Condition(s):
Street Address City State Zip	Fax Number ()	Period of Treatment:
Physician Name:	Phone Number ()	Condition(s):
Street Address City State Zip	Fax Number ()	Period of Treatment:

Additional Documentation (Please attach the following documents to this form.)

- Beneficiary Statement(s)
- Original certified Death Certificate (cause of death and manner of death must be determined)
- For Suicide, Homicide, Accidental Death Claims, please attach police, coroner, and toxicology reports

Beneficiary Information and Acknowledgement I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.

Beneficiary Name (Last, First, Middle Initial):	Social Security #	Mailing Address City State Zip		
Beneficiary Signature	Date Signed	Date of Birth	Phone Number	Relationship to Deceased
Beneficiary Name (Last, First, Middle Initial):	Social Security #	Mailing Address City State Zip		
Beneficiary Signature	Date Signed	Date of Birth	Phone Number	Relationship to Deceased
Beneficiary Name (Last, First, Middle Initial):	Social Security #	Mailing Address City State Zip		
Beneficiary Signature	Date Signed	Date of Birth	Phone Number	Relationship to Deceased
Beneficiary Name (Last, First, Middle Initial):	Social Security #	Mailing Address City State Zip		
Beneficiary Signature	Date Signed	Date of Birth	Phone Number	Relationship to Deceased

For additional beneficiaries, please complete and attach separate sheet.



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Insurance Fraud Warning

Unless specific state language is provided below, the following fraud notice applies: 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.

Arizona Residents: 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.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

Colorado Residents: 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.

District of Columbia Residents: 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.

Florida Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Alabama, Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas and West Virginia Residents: 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.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: 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 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.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Ohio Residents: Any person who, with 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.

Maine, Tennessee, Virginia and Washington Residents: 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.

Alaska and Oregon Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

Delaware, Idaho, Indiana and Oklahoma Residents: 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.



Life Insurance Benefit Claim Form

Employer's and/or Administrator's Statement

Information about Deceased and Member

Name of Deceased (Last, First, Middle Initial) <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Dependent Child		Date of Birth	Date of Death	Social Security Number
Name of Member, if not the deceased (Last, First, Middle Initial)		Date of Birth	Social Security Number	
Member Address Street & No.		City	State	Zip
Date of Membership/Employment:	Date Member Last Worked: Full Time: _____ Part Time: _____		Date of Employment Termination: <input type="checkbox"/> N/A	
Reason for member stopping work: <input type="checkbox"/> Disability <input type="checkbox"/> Dismissed <input type="checkbox"/> Resigned <input type="checkbox"/> Layoff <input type="checkbox"/> Retired <input type="checkbox"/> Family Medical Leave of Absence <input type="checkbox"/> Other Leave of Absence <input type="checkbox"/> Other Reason:		Amount of Insurance Being Claimed: Basic Life: \$ _____ Accidental Death: \$ _____ Voluntary Life: \$ _____ Dependent Life: \$ _____ Other (specify): \$ _____ Dependent Voluntary Life: \$ _____		
Employee's Earnings: \$ _____ Regular scheduled hours per week: _____		Occupation: _____		
Date of last increase: _____ Earnings prior to increase: \$ _____		Last month premium was paid for member or dependent: _____		
<input type="checkbox"/> hourly <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annual <input type="checkbox"/> commission <input type="checkbox"/> shift differential <input type="checkbox"/> bonuses <input type="checkbox"/> other:				

Information about Member's Coverage

Employee Life Insurance coverage: Effective Date _____ Coverage Termination _____ of Coverage: _____ Date: _____	Member also had the following coverage with LifeMap Assurance Company: <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Waiver of Premium
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Beneficiary Information (Please have Beneficiary Statement form completed for each beneficiary)

Name of	Social Security	Relation	Date of	Address	Phone

Additional Information

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Additional Documentation (Please attach the following documents to this form.)

Original enrollment/beneficiary designation forms and all subsequent changes. **If no original on file:** (circle) copy-scan-electronically captured-not on file

Information about Employer or Benefit Administrator

Employer or Association Name Cassia Jt School District No 151	Location/Class Code (if applicable)	Policy Number ID03902I
Employer or Association Address Street & No. 3650 Overland	City Burley	State Zip ID 83318
Name and title of Employer/Association Representative completing this form Kathy Eklund, Human Resources Clerk		Phone Number (208) 878-6600
		Email Address eklkathy@cassiaschools.org

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief.
I acknowledge that I have read the fraud notice on page 6 of this form.

Signature of Employer/Association Representative Date



Life Insurance Benefit Claim Form

Policyholder's Statement

(Complete if Policyholder is different than Employer)

Information about Deceased and Member

Name of Deceased (Last, First, Middle Initial) <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Dependent Child		Date of Birth	Date of Death	Social Security Number
Name of Member, if not the deceased (Last, First, Middle Initial)		Date of Birth	Social Security Number	
Employee's Effective Dates of Coverage with LifeMap: From: _____ Through: _____	Amount of Insurance Elected By Member:			
	Basic Life: \$		Accidental Death: \$	
Employee's Premium Paid Through Date:	Voluntary Life: \$		Dependent Life: \$	
	Other (specify): \$		Dependent Voluntary Life: \$	

Information about Participating Employer

Participating Employer Name			Employer's Effective Dates with LifeMap From: _____ Through: _____	
Employer's Eligibility Requirement (Hours Per Week)	Amount of Insurance Offered By Group:			
	Basic Life: \$		Accidental Death: \$	
Eligibility Waiting Period	Voluntary Life: \$		Dependent Life: \$	
	Other (specify): \$		Dependent Voluntary Life: \$	
Employer Address	Street & Number	City	State	Zip
				Phone Number ()
Employer Representative Name				Email Address

Information about Policyholder

Policyholder Name		Policyholder Effective Date		Policy Number
Policyholder Address	Street & Number	City	State	Zip
				Phone Number ()
Name and title of Policyholder Representative completing this form				Email Address

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 6 of this form.

▶ _____ ▶ _____
Signature of Policyholder Representative Date



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New York Residents: 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 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.

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