

Administrative Office:
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Minneapolis, MN 55440-1588
(952) 936-6050

United HealthCare Insurance Company
United HealthCare Insurance Company of Ohio
United HealthCare Insurance Company of Illinois

PROOF OF DEATH FOR GROUP INSURANCE

INSTRUCTIONS:

1. Claimant please fill in and sign section below.
2. Certified Death Certificate must be included in proofs.
3. Attach copy of police report, if accidental

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a notice of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

SECTION 1

CLAIMANT'S SIGNATURE

I hereby make claim for the death benefits on the life of

Under Group Policy Number	S.S. Number	(Insured).
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If a dependent, name of insured

Address

insured in the (Name of Group)

Deceased date of BIRTH

Deceased's date of DEATH

Place of death (if in hospital, give name and address of hospital)

Cause of death

State your relationship to Deceased

Your date of birth

Your Name

Telephone Number

Your Address

SIGNATURE AND SOCIAL SECURITY VERIFICATION

Please review the following statement and sign your name the way you would ordinarily sign a check. We are requesting your signature for two purposes: first, to certify your Social Security number; and second, to confirm your signature for the bank that will clear your checks.

Under the penalties of perjury, I certify that (1) the number I have documented on this form is my correct taxpayer identification number, and (2) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.

Social Security Number or Taxpayer Identification Number

Signature
(IMPORTANT: Sign your name the way you would ordinarily sign a check)

Date

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that by furnishing the form and investigating the claim, the United HealthCare Insurance Company shall not be held to admit validity of any claim, or waive any of its rights, or any of the conditions of the policy. I hereby authorize United HealthCare Insurance Company to obtain any medical or hospital records on the deceased. A photostat of this authorization will be as valid as the original authorization.

SECTION 2

STATEMENT OF EMPLOYER

We certify that, to the best of our knowledge and belief, the following statements and answers are true:

Full Name of Employee

Address of Employee Street Address

City

State

Zip

Name of group

Employee's Social Security Number

Date to which Employee's Individual Premiums are paid

Date of Employment

Date of Last Active Service

If Employee not actively at work on date of death, give reason:

- Discharged
- On Leave of Absence
- Quit
- On Vacation
- On Disability
- Temporary Work Stoppage
- Other, explain _____

Occupation or Class of Insured

Basic Amount of Life Insurance \$

Supplemental Life Insurance \$

Name of Beneficiary

Relationship

Comments:

AUTHORIZED OFFICIAL MUST SIGN BELOW:

Name of Employer

Address of Employer

Signature of Employer