



Group Life and Accidental Death Claim Form

Please accept our deepest sympathies for your loss. At this difficult time, our goal is to service your claim quickly and accurately. Thank you, in advance, for providing us with the information we need by following the instructions below.

General Instructions: Please Read this Page Before You Fill Out the Claim Form

Please provide us with written notice of the claim within 30 days after the date of death followed by written proof of loss (this completed claim form and all supporting documents) within 90 days after the date of death.

To complete processing of the claim, we must have:

1. An original certified Death Certificate bearing the seal of the appropriate local, state or federal agency issuing the certificate along with this form. A copy is acceptable.
2. Autopsy report/coroner's report, if performed, including a toxicology report.
3. Newspaper articles, if the death was accidental and articles are available.
4. Police, Fire and/or Accident Report, if the death was accidental.
5. A separate Beneficiary Statement (Section 2) for *each* beneficiary.
6. A fully completed copy of the Employer's Statement (page 3 below).

Be sure to keep a copy of all the documents for your records

Employer Instructions

1. Provide each beneficiary with a Claim Form, a Beneficiary Statement and a completed Employer Statement (including any attachments).
2. Complete the Employer Statement and attach a copy of the most recent beneficiary designation information. If a beneficiary entitled to a benefit is deceased, please provide name, date of death and a copy of his/her certified death certificate. (Please note that the insured employee is automatically the beneficiary for all dependent death claims.)
3. Once completed, either you or the beneficiary(ies) should send this claim form and all required documentation to Nationwide.

Beneficiary / Claimant Instructions

1. Please complete all sections of the Beneficiary Statement. If there are multiple beneficiaries, each individual must complete a separate Beneficiary Statement. If necessary, please include a separate sheet listing all addresses at which you have lived in the past two years.
2. Submit your completed claim form, including any applicable supporting documentation listed above via one of these methods.
 - a. Mail: Nationwide P.O. Box 1910, Covington, LA 70434
 - b. Fax to: 985-898-1770
 - c. E-mail to service@nebsupport.com
3. If you have any questions, please contact Customer Service at (877) 717-4455.



Group Life and Accidental Death Claim Form Beneficiary Statement

Please type or print legibly.

Section 1: Information about the Insured (Deceased)

Name of Insured (First, MI, Last)	Insured's Social Security Number
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Section 2: Claim Payment Options

Please select one of the following benefit payment options:

I authorize Nationwide to deposit my life proceeds into my personal bank account. As a convenience to me, I authorize Nationwide Insurance and its authorized representative, Gilsbar, L.L.C., Covington, LA (TIN #72-0519951), to deposit claim payments and, if necessary, make adjustments for any error to my account.

Bank Name _____ Name on Bank Account _____
Checking Savings

Please submit a voided blank check or a copy of a bank statement, direct deposit authorization form or other documentation showing the routing and account numbers.

Authorized Signature _____ Date _____

Please send a lump sum check to me for all life insurance proceeds.

(If you wish the proceeds to be paid directly to a funeral home, please obtain an Absolute Assignment from your funeral director. By law this form can only be used to authorize payment to you as the beneficiary.)

Section 3: Claimant / Beneficiary Information – Please Complete this Section with Your Information

Are you making this claim as the Beneficiary? No Yes. My relationship to the deceased is: _____

Are you making this claim as the Administrator, Guardian or Executor? No Yes. Please provide appropriate proof.

Name (First, MI, Last)	Social Security Number	Date of Birth
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Residential Address – No P.O. Box (Street Name/Number, City, State, Zip)

Mailing Address, if Different (Street Name/Number or P.O. Box, City, State, Zip)

Driver's License or Other ID Number	State of Issue	<input type="checkbox"/> Driver's License <input type="checkbox"/> Government ID <input type="checkbox"/> Military ID
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Daytime Telephone Number	E-mail address (optional)
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Complete only if the beneficiary is a trust or estate:	Trust or Estate Name	Trust or Estate TIN
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Section 4: Important Information

Claims by a Trust, Estate or Assignee: If you are filing this claim as a Trustee, Executor or Administrator, you must complete and sign this statement and submit certified copies of the appointment papers. Please be sure to indicate the Trust or Estate TIN above.

Assignment of Benefits: If any portion of the benefits has been assigned, please include a copy of the assignment.

Beneficiary Signature: Please sign the Beneficiary Statement below in the same manner as you would sign checks. You will also be certifying, under penalties of perjury, that your SSN or TIN are accurate.

Section 5: Certification and Signature

I certify that I have read the applicable State Fraud Notice on the last two pages. I certify that the above information is correct to the best of my knowledge and belief. Under penalties of perjury, I certify that:

- (1) The number shown on this form is my correct taxpayer identification number, and
- (2) I am not subject to backup withholding because (a) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (b) the Internal Revenue Service has notified me that I am no longer subject to backup withholding, or that I am exempt from backup withholding, and
- (3) I am a United States citizen (including a U.S. resident alien).

You must cross out item (2) if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.

(New York) 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.

By signing below, I am providing consent to Nationwide Employee Benefits to receive claim documents and communications electronically. Please refer to the terms and conditions on page 5. If you do not consent to Electronic Delivery of Insurance Documents, please check here .

Beneficiary's Signature	Date
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Not for use by beneficiaries. Please type or print legibly.

Section 1: Policy and Employer Information	
Group Name	Group Number
Direct All Correspondence on this Claim to:	Telephone Number
Address (Street Name/Number, City, State, Zip)	E-mail Address

Section 2: Employee Information			
Employee Name (First, MI, Last)		SSN	Date of Birth
Work location/Division:	Occupation/Job Title:	Rate of Pay (at date last worked) \$ _____ per	Date Employed
Did the insured meet the definition of Actively at Work at the time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Explain:			Date Last Worked

Was a claim for Waiver of Premium or Continuation due to total disability benefits submitted prior to death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of Death	Original Date Insured with Nationwide	Insurance Termed prior to death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is/Was Employee: Full Time <input type="checkbox"/> Yes <input type="checkbox"/> No Part-Time <input type="checkbox"/> Yes <input type="checkbox"/> No Hours Worked Per Week _____			
Reason for Employee Leaving Work:			
If more than thirty one days elapsed between date last worked and date of death, do you consider death occurred while he/she was <input type="checkbox"/> Retired Employee <input type="checkbox"/> Absent on Sick Leave <input type="checkbox"/> Totally Disabled <input type="checkbox"/> Absent due to Temporary Lay-Off <input type="checkbox"/> No Longer Employed			

Amount of Insurance at Time of Death			
Basic Life \$	Voluntary Life \$	Basic AD&D \$	Voluntary AD&D \$

Section 3: Dependent Information – Complete <u>Only</u> if this Claim is for an Insured Dependent				
Insured Dependent Name (First, MI, Last)		Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	SSN
Address (Street Name/Number, City, State, Zip)				
Relationship to Insured Employee:			If spouse, was he/she divorced or legally separated from the employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If child, was he/she: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Was the dependent confined to a hospital, facility or at home on the effective date of coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Explain:				
Was dependent insured at the time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No – Explain:		Date of Death	Amount of Dependent's Insurance \$	

Section 4: Accidental Death Claim Information – Complete Only if Death was Due to an Accident and Your Group Plan Provides an Accidental Death Benefit. Refer to the Instructions Above for a List of Necessary Supporting Documentation.	
Date of Accident	Describe in detail how the accident occurred:
Place of Accident	Was the employee in a coma prior to death? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the employee have a child who is a full-time college student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the death arise out of and during the course of employment? <input type="checkbox"/> No <input type="checkbox"/> Yes

VERY IMPORTANT: ERISA	
Is Employer subject to ERISA compliance? <input type="checkbox"/> No <input type="checkbox"/> Yes	

Section 5: Certification and Signature	
I certify that the above information is correct and complete according to our records. I certify that I have read the applicable State Fraud Notice on page 4.	
<small>(New York) 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.</small>	
By signing below, I am providing consent to Nationwide Employee Benefits to receive claim documents and communications electronically. Please refer to the terms and conditions on page 5. If you do not consent to Electronic Delivery of Insurance Documents, please check here <input type="checkbox"/>.	
Name of Employer's Authorized Representative (printed)	Title
Signature of Employer's Authorized Representative ▶	Date

State Fraud Notices

- (Alabama)** Any person who knowingly presents a false or fraudulent claim for payment of 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.
- (Alaska)** A 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.
- (Arizona)** Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
- (Arkansas)** 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.
- (California)** 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.
- (Colorado)** 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.
- (Delaware)** 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.
- (District of Columbia)** 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.
- (Florida)** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- (Idaho)** 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.
- (Indiana)** 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.
- (Kentucky)** 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.
- (Louisiana)** 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.
- (Maine)** 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.
- (Maryland)** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- (Minnesota)** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
- (New Hampshire)** 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.
- (New Jersey)** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
- (New Mexico)** 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.
- (New York)** 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 \$5,000 and the stated value of the claim for each such violation.
- (Ohio)** 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.
- (Oklahoma)** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- (Pennsylvania)** 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.
- (Rhode Island)** 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.
- (Tennessee)** 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.
- (Texas)** 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.
- (Virginia)** 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.
- (Washington)** 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.
- (West Virginia)** 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.



Terms and Conditions of Electronic Delivery of Insurance Documents

In order for Nationwide Employee Benefits (hereinafter referred to as “we” or “us”) to send you your insurance-related documents and communications electronically, to the extent permitted by law, you must first consent to us doing so. The insurance-related documents and communications you will receive in electronic format will have the same contractual force and effect as insurance-related documents and communications sent to you in paper format. We reserve the right, in our sole discretion, to provide any insurance-related documents and communications to you in paper form instead, and / or to discontinue this service or modify the terms of this agreement at our option. If we do, we will provide you with reasonable notice and you will have the option to withdraw your consent at that time.

YOUR CONSENT: By NOT checking the box in Section 5 Page 2 or Section 5 Page 3, you:

1. Consent to receive insurance-related documents and communications, including but not limited to, your policy documents, disclosures, notices, explanation of benefits (EOB), claims documentation, **as well as termination and cancellation or non-renewal notices**, electronically to the email address you provide to us on the claim form instead of receiving these records in a paper format from **Nationwide Employee Benefits**.
2. Agree and acknowledge that your consent is provided and/or obtained in connection with a transaction affecting interstate commerce subject to the Electronic Signatures in Global and National Commerce Act and the Uniform Electronic Transactions Act, or a similar electronic transactions law, as adopted by state law.
3. Agree that the document(s) delivered to you electronically shall have the same meaning and effect as if you were provided a paper document, whether or not you choose to view the document(s), unless you previously withdrew your consent to receive documents via electronic means as provided below. Electronic document(s) are considered received by you at the time the documents are sent, unless Nationwide receives notice that the email notification was not delivered to you at the email address you provided.

YOUR RIGHT TO WITHDRAW YOUR CONSENT: If you consented to receiving insurance-related documents and communications electronically, you may withdraw your consent at any time. After we process your withdrawal of consent, you will begin receiving your insurance documents and correspondence in paper form. To withdraw your consent, please send a written request to Nationwide Employee Benefits, PO Box 1910, Covington, LA 70434.

YOUR RIGHT TO RECEIVE PAPER COPIES: You have the right to obtain paper copies of your insurance-related documents and communications at any time. To obtain paper copies, please contact Nationwide Employee Benefits at 1-877-717-4455, service@nebsupport.com, or PO Box 1910, Covington, LA 70434.

YOUR OBLIGATIONS: If you consent to receive insurance documents and correspondence electronically, you are responsible for (i) providing Nationwide with an updated and active e-mail address through the contact listed below. You should be diligent in updating your email address with us in the event that your address changes; (ii) maintaining or having access to a computer capable of connecting to the internet; (iii) maintaining internet access; (iv) installing software on your personal computer to receive, access, store, and print in accordance with the Technical Requirements listed below; (v) an email service account that allows you to read, write, and send email; (vi) an active email address

UPDATING YOUR CONTACT INFORMATION: It is your responsibility to provide Nationwide Employee Benefits with a current, valid email address and to promptly update any changes to this information by contacting us at 1-877-717-4455, service@nebsupport.com, or PO Box 1910, Covington, LA 70434.

UNDELIVERABLE AND RETURN EMAILS: Any e-mails returned as undeliverable will result in a suspension of electronic document delivery and a return to paper copies sent via U.S. mail.

TECHNICAL REQUIREMENTS: The following minimal technical requirements are necessary to receive electronic records:

E-Mail – Access to an email account with a provider such as Gmail®, Outlook®, or Yahoo!®
PDF Reader – Acrobat® or similar software may be required to view and print PDF files