Aetna™

Proof of Death

Group Life Insurance and Group Accidental Death Benefit Request
(Filing instructions on reverse side)

Submit To:
Aetna Life Insurance Company
P.O. Box 14549
Lexington, KY 40512-4549

A. Information About the Deceased

Deceased's Name (last, first, middle initial)	Relationship to Employee			
Social Security Number	Birthdate (MM/DD/YYYY)	Date of Death (MM/DD/YYYY)	Age	Sex ☐ Male ☐ Female
Last Residence: Street	City		State	Zip

B. Information About the Employee

Employee's Name (last, first, middle initial)	Social Security Number	Birthdate (MM/DD/YYYY)

Date Employed (MM/DD/YYYY)	☐ Hourly ☐ Salary	Date Last Worked (MM/DD/YYYY)	Reason employee did not return to work after last day worked.

Last Residence: Street	City	State	Zip

C. Information About the Employee's Coverage

Employer's Name	Representative's / Contact's Name		
Street Address	City	State	Zip

Telephone Number ( )	Was Accelerated Death benefit claim submitted prior to death? ☐ No ☐ Yes	Was waiver of premium claim submitted prior to death? ☐ No ☐ Yes

Coverages for which benefits are in effect and being claimed

Group Coverage	Control	Suffix	Account	Plan	Effective date of employee's insurance (MM/DD/YYYY)	Amount of insurance in force as of the date last worked
☐ Term Life (TRM1)					/ /	
☐ _____					/ /	
☐ Supplemental (TRM3)					/ /	
☐ _____					/ /	
☐ Dependent (TRM2)					/ /	
☐ [AD&PL (AD&D)] (ADD1)					/ /	
☐ Group Accident (GAC1)					/ /	
☐ Paid-up (PUP1)					/ /	
☐ Group Universal Life (GUL1)					/ /	
☐ _____					/ /	

If insurance is based on earnings, basic rate of earnings on date last worked. or frozen salary	If insurance based on other than earnings, identify basis (i.e., job class, union, etc.).
$ _____ per ☐ Hour ☐ Week ☐ Month ☐ Year	

Date of Last Salary Increase (MM/DD/YYYY)	Has amount of insurance increased (other than salary) within the last two years? ☐ No ☐ Yes If Yes, give date _____ (MM/DD/YYYY)	Was employee required to submit evidence of insurability to secure current coverage? ☐ No ☐ Yes

Identify last period covered by employee or employer contributions/premiums.	If insurance is not in effect, give date discontinued (MM/DD/YYYY)

Deceased Information

Name (last, first, middle initial)

Social Security Number

D. Information About The Beneficiary(ies)

	1.	2.	3.
Name			
Street			
City			
State/Zip			
Social Security Number			
Relationship to Employee			
Birthdate (MM/DD/YYYY)			
Telephone number			
Home	( )	( )	( )
Work	( )	( )	( )

Has ownership been assigned?	If yes, to whom? (send copy of assignment)	Assignee's Social Security Number
☐ No ☐ Yes		

E. Benefit Distribution Instructions

Return the benefit payment directly to:

☐ Beneficiary ☐ Beneficiary with copy to employer ☐ Employer ☐ Other _____

F. Employer's Instructions

- Please submit this form, with the following attachments to the Life Insurance Service Center as soon as possible.
  - The insured's death certificate*.
  - Original beneficiary designation and any or all change of beneficiary requests.
  - Enrollment forms (current and prior two years).
  - If beneficiary(ies) are minor children:
    a) Their birth certificates & Social Security numbers*
    b) Letters of Guardianship* or conservatorship of the **estate** of the minor child*
  - If beneficiary is the insured's estate:
    a) The Letters of Administration or Letters of Testamentary.*
  - If beneficiary is a trust:
    a) Provide copies of trust and letter of acceptance from trustee with Trust ID number.
  - If designated beneficiary predeceased the employee:
    a) A copy of the beneficiary's death certificate
    b) Names, addresses, relationship of the employees next of kin, if the policy contains a next in line provision.
  - If Accidental Death benefits are being claimed, submit police/accident report with any available newspaper clippings concerning the accident.*
- Complete the deceased name on the top of Page 2 before the Life insurance claim is faxed to our office at **1-800-238-6239** or **1-800-AetnaFx**. It is not necessary to follow-up with the original documents.

If you have any additional questions on the submission of this claim, please contact our office at **1-800-523-5065**.

* This information should be supplied by the beneficiary or the beneficiary's representative.

G. Employer's Authorized Representative

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 claim was provided by the applicant.

California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

Pennsylvania 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 and subjects such person to criminal and civil penalties.

Name _____ Signature _____

Date (MM/DD/YYYY) _____ at (city, state, zip) _____