Madison National Life

Insurance Company, Inc.
P.O. BOX 2865 CLINTON, IA 52733-2865
Telephone: 800-356-9601 Extension 2410 Fax: 608-830-2701

GROUP TERM LIFE INSURANCE CLAIM FORM

By furnishing forms and investigating the claim, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

Please read the instructions below carefully to assure a timely review of your claim for life insurance proceeds.

To review this claim we will require:
1) a certified death certificate; and
2) a copy of the most recent beneficiary designation form; and
3) a copy of the deceased's timecard or attendance record from his/her employer unless disabled prior to the date of death, or retired; and
4) a copy of the obituary, if available.

If any of the following situations apply to this claim, please provide the information documented below:

- If the death was the result of an accident, we must receive a copy of the official accident report from the responding legal authorities.
- If there is more than one beneficiary, each beneficiary must complete the beneficiary information on this form**.**
- If the policy is payable to the estate, executors or administrators of the insured, the statement should be completed by the executor or administrator. Documents confirming appointment as executors or administrators must be furnished.
- If the policy is payable to a minor or a mentally incompetent individual, the statement should be executed by the court appointed **l**egal guardian and a certificate of appointment and qualifications must be furnished.
- If a beneficiary is deceased, a certified death certificate for the deceased beneficiary(ies) must also be furnished.

EMPLOYER'S STATEMENT

Employer's name:_____ Group/Policy number:_____

Name of deceased**:** _____ Social security number:_____

If the claim is being filed for an insured dependent, provide the insured employee's name: _____

Employee's address:_____
Street City State Zip Code

Employee's date of hire:_____ Employee's occupation:_____

Last date employee actually worked:_____ Average number of hours employee worked/week:_____

Employee's annual salary:_____ Was the employee retired? ☐ No ☐ Yes If yes, date_____

Amount of Coverage

Basic Group Term Life: $ _____ **Basic Accidental Death and Dismemberment: $** _____

Supplemental Group Term Life: $_____ **Supplemental Accidental Death and Dismemberment: $** _____

Dependent Group Term Life: $ _____

Name and title of individual completing this form (please print):_____

Telephone number:_____ Fax number:_____

Signature:_____Date:_____

BENEFICIARY'S STATEMENT

Name of deceased: _____ Deceased's date of birth: _____

Date of death:_____ Cause of death:_____

When did deceased give indication or first seek medical attention for his/her last illness?_____

CONTINUED ON REVERSE

Please list names of the facilities at which the deceased received treatment within the last five years preceding death:

NAME	ADDRESS	TELEPHONE NUMBER	DATES OF ATTENDANCE
NAME	ADDRESS	TELEPHONE NUMBER	DATES OF ATTENDANCE
NAME	ADDRESS	TELEPHONE NUMBER	DATES OF ATTENDANCE

BENEFICIARY 1

Name:_____

Date of birth: _____ Relationship:_____

Social security number:_____

Telephone number :_____

Complete address:_____

_____

Signature: Date:

BENEFICIARY 2

Name:_____

Date of birth: _____ Relationship:_____

Social security number:_____

Telephone number :_____

Complete address:_____

_____

Signature: Date:

BENEFICIARY 3

Name:_____

Date of birth: _____ Relationship:_____

Social security number:_____

Telephone number :_____

Complete address:_____

_____

Signature: Date:

BENEFICIARY 4

Name:_____

Date of birth: _____ Relationship:_____

Social security number:_____

Telephone number :_____

Complete address:_____

_____

Signature: Date:

Authorization

I agree that the written statements of all physicians who attended or treated the deceased and all other papers called for by Madison National Life Insurance Company, hereafter called the Company, shall constitute, and they are hereby made a part, of these proofs of death and further agree that all provisions of law forbidding any physician or other person who attended deceased from disclosing any knowledge or information acquired by him are hereby waived.

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically-related health care facility or health care provider, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency or employer, having information available concerning the diagnosis, treatment or prognosis of any physical or mental condition of the deceased, to give to the Company, or its legal representative any and all such information.

I understand the information obtained by use of this Authorization will be used by the Company to determine eligibility for benefits under an existing policy. Any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application or claim or as may be otherwise lawfully required or as I may further authorize.

I understand that I may receive a copy of this authorization upon request, agree that a photographic copy of this Authorization shall be as valid as the original and agree that this Authorization shall be valid for two years from the date shown below.

I have received and read the fraud warning statements provided with this form

_____ _____

Signature of Beneficiary 1 Date

_____ _____

Signature of Beneficiary 2 Date

_____ _____

Signature of Beneficiary 3 Date

_____ _____

Signature of Beneficiary 4 Date

Fraud Warnings

WARNING: 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, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, West Virginia, Wisconsin and Wyoming.

ALABAMA WARNING: 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.

ARIZONA WARNING: 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 WARNING: 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 WARNING: 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 damage. 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 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 WARNING: 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.

KENTUCKY WARNING: 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 WARNING: 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.

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

NEW MEXICO WARNING: 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.

OHIO WARNING: 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.

PENNSYLVANIA WARNING: 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.

TENNESSEE WARNING: 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.

VIRGINIA WARNING: 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 WARNING: 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.

Signature:_____ Date:_____