Aflac
Underwritten by Trustmark Life Insurance Company of New York

Death Benefit Claim NY

For Claims Customer Service: ☎ **Phone:** (800) 225-3859
For Claims Submission: 🖷 **Fax:** (508) 853-0310 ✉ **Email:** Claims@ULAflac.com
Mail: Attn: Life Claims PO Box 60676, Worcester, MA 01606

Instructions

- The ***Statement of Physician*** section must be completed by the deceased's primary care physician, **ONLY** if the death occurred within the first two (2) years from the effective date of the policy.
- A ***Beneficiary's Statement*** must be completed by the person to who the insurance is payable. In connection with such statement, the following should be observed:
    1. If there is ***more than one beneficiary***, all may join in one statement or a separate form will be furnished for each if desired.
    2. If the policy is ***payable to the estate or to the executors or administrators of the insured***, the statement should be completed by the executor or administrator, a certificate of whose appointment and qualifications must be furnished.
    3. If the policy is ***payable to a minor or a mentally incompetent person***, the statement should be completed by a guardian, a certificate of whose appointment and qualifications must be furnished.
    4. If the policy has been ***assigned***, special instructions will be furnished.
- A ***Certified Copy of the Death Certificate*** must be furnished for ***insured***.
- A ***Certified Copy of the Death Certificate*** for any ***deceased beneficiary*** must be furnished.
- If the cause of death is due to an injury or accident, please enclose a photocopy of the police report and/or newspaper articles concerning the circumstances.

Section A – Beneficiary's Statement

Policy / Certificate #: _____

Deceased's Full Name: _____

Residence Address: _____
Street City State Zip Code

Deceased's DOB: ____/____/____ Place of birth: _____

Occupation at death: _____ Date last worked? ____/____/____

Date of death? ____/____/____ Place of death: _____

Cause of death: _____

When did deceased first complain of or give other indications of the last illness? ____/____/____

When did deceased first consult a physician for the last illness? ____/____/____

Names & addresses of all physicians or practitioners who attended or prescribed for deceased within the five years preceding death			
Physician Name	**Address**	**Dates of Attendance**	**Disease or Condition**

Has deceased at any time been confined to a hospital? ❑ Yes ❑ No If yes, when? ____/____/____

If yes, where? _____

If optional settlement is available, and you do not desire payment in one sum, state type of settlement desired: _____

_____

****** Complete & Sign Disclosure Authorization Portion of Claim Form ******

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Section B – Attending Physician's Statement *(To be completed by the Attending Physician)*

Deceased's Full Name: _____ Age At Death: _____

Residence at death: _____ Occupation: _____

How long have you known the deceased? _____

Date & Time of death? ____/____/_____ _____ Place of death: _____

If death occurred in hospital, please give name & address: _____

When you were first consulted for the condition which directly or indirectly caused death: ____/____/____

What was the immediate cause of death? _____

How long, in your opinion, did this disease or impairment exist? _____

What was the date of onset of the first symptom or sign according to the clinical history? ____/____/____

From what date was the patient continuously totally disabled prior to death? ___/___/___

Contributory cause of death: _____ Duration: _____

Other chronic diseases or impairments:_____ Duration: _____

If death was due to suicide, homicide, or accident, complete this section

Cause of death: ❑ Suicide ❑ Homicide ❑ Accident

Please describe briefly: _____

Was an official inquiry held? ❑ Yes ❑ No Was a post-mortem examination made? ❑ Yes ❑ No

Was blood alcohol level and/or drug level taken? ❑ Yes ❑ No If yes, findings? _____

Please give particulars of each condition for which you treated or advised deceased prior to last illness

Disease or Condition	Date	Duration	Result

Please give name & addresses of all other physicians or other practitioners who attended deceased within the five years preceding death

Physician Name	Address	Phone	Disease or Condition

Physician's name (please print)_____ Specialty_____

Phone: _____-_____-_____ Fax: _____-_____-_____

Address: _____
Street City State Zip Code

Signature_____ Date ____/____/____

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DISCLOSURE AUTHORIZATION

Insured's Name (Please Print):_____

I AUTHORIZE any doctor, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, consumer reporting agency, insurance support organization, insurance agent, employer, financial institution, the Social Security Administration, the Internal Revenue Service, the Veterans Administration or any other organization or person having any knowledge of me or my health to give to Trustmark Life Insurance Company of New York and affiliates or its employee and agents, or any other consumer reporting agency any information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to my physical or mental condition or information concerning me, my occupation, employment history, earnings or finances or information otherwise needed to determine policy claim benefits due me. This may include, but is not limited to, HIV Infection, any disorder of the immune system including Acquired Immune Deficiency Syndrome (AIDS), driving records, mental illness, or use of alcohol or drugs.

I further AUTHORIZE the Social Security Adm. to release information or records about me to Trustmark Life Insurance Company of New York or authorized representatives. This information is to be released in order to properly adjudicate my claim or continue my eligibility for benefits. Please release detailed earnings for up to the last ten years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits.

This authorization may be revoked by me. Any such revocation must be in writing, must be signed and dated by me and must be forwarded directly to the Trustmark Life Insurance Company of New York. I AGREE the information obtained with this Authorization may be used by Trustmark Life Insurance Company of New York and affiliates to determine policy claim benefits with respect to the Insured. A photocopy of this authorization is as valid as the original and I may request a copy. This authorization will be in force for the term of coverage of the policy up to 12 months from the date shown below. I understand that if I revoke or fail to sign this authorization or alter its content it may affect the handling of my claim including denial of benefits under my policy.

I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I AUTHORIZE Trustmark Life Insurance Company of New York and affiliates to report to ICS, any dates of past or present claims filed by me.

Residents of NY – 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 or each such violation.

Signature: _____ Date Signed: ___/___/___

Printed Name: _____ Date of Birth: ___/___/___ SSN: _____

Relationship: _____ Daytime Phone Number (____) _____-_____

Residence Address: _____
Street City State Zip Code

Signature: _____ Date Signed: ___/___/___

Printed Name: _____ Date of Birth: ___/___/___ SSN: _____

Relationship: _____ Daytime Phone Number (____) _____-_____

Residence Address: _____
Street City State Zip Code

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Beneficiary Statement of Claim – Communication

CONSENT FOR USE OF ELECTRONIC COMMUNICATIONS (EMAIL, SMS/MMS TEXT MESSAGING)

To ensure the best and fastest communication, we would like to communicate with you using either email or text messaging. Please complete this section if we can communicate with you electronically, concerning your claim, benefits, policy, premium or condition.

May we communicate with you electronically?

❑ No

❑ Yes, by Text Messages - Please provide cell phone #: (_____) - _____ - _____

❑ Yes, by Email Please provide email address: _____@ _____

If you chose to communicate with us electronically, you should be aware that electronic communication is not secure unless it is encrypted. We strongly encourage you to use encrypted communication when sending sensitive and/or confidential information. By sending sensitive or confidential electronic messages that are not encrypted, you accept the risks of such lack of security and possible lack of confidentiality. If you elect to communicate from your workplace computer, you should also be aware that your employer and its agents, have access to electronic communication between you and us.

I understand that by selecting text messaging, regular text messaging rates may apply for any texts I receive from Trustmark Life Insurance Company of New York and I assume responsibility for any costs associated with these text messages. This consent shall remain in effect unless revoked in writing.

To ensure a smooth email experience, please be sure that your computer has the most up to date version of Adobe Reader. You should add our email address to your address book contact list and add us to your email server or spam filter approved listing. If you don't see email from us in your email inbox, be sure to check your spam, clutter, junk or bulk email folder. You can choose to stop electronic communication at any time by revoking this authorization. If you no longer wish to communicate via electronic means we will correspond with you via US mail. If you require copies of any communication sent to you by email/text in paper form, please contact us. There is no cost to you to obtain copies of electronic communication in paper format.

Authorization

I may revoke or update this authorization in writing at any time or by email to **Claims@ULAflac.com**.
Trustmark Life Insurance Company of New York may rely on the information I provide for the adjudication of my claim as a result of this authorization until receipt of my revocation notice. This authorization is valid for two (2) years. I may request a copy of this authorization and a copy is as valid as the original.

_____ _____

Policy Owner or Beneficiary Signature ***Date***

_____ _____

Printed Name ***Social Security Number***