Clear Form

IN FURNISHING THIS FORM HARTFORD LIFE DOES NOT WAIVE ANY OF ITS RIGHTS OR DEFENSES NOR ADMIT LIABILITY

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
PROOF OF DEATH (Group Life Insurance)

Mail to: The McKellan Group, Inc.
1449 Old Waterbury Rd #201
Southbury, CT 06488

Questions 1-800-531-2001 / Fax# 203-575-0308

STATEMENT OF EMPLOYER

Full Name of Employee *(Last, first, middle initial)*	Employee Social Security No.	Last Residence *(No. Street, City or Town, State, Zip Code)*

Employer	Branch or Subsidiary	Date of Birth	Date Employed

Policy Number	Date of Death	Effective Date of Employee's Insurance	Date Last Actively at Work

Reason employee did not return to work after last day worked:	Have premiums been paid to date for this insured? ☐ Yes ☐ No	Occupation	Classification

AMOUNT OF INSURANCE BEING CLAIMED

Basic Life:	AD&D Basic:
Supplemental Life:	AD&D Supplemental:

Benefit based on previous year's W-2? ☐ Yes ☐ No	Do age reductions apply? ☐ Yes ☐ No

Was an application for conversion completed? ☐ Yes ☐ No

Date insurance was discontinued, if not in force:

(Complete only if amount of insurance is based on earnings schedule.)

Rate of basic earnings on date last worked: $ _____

☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually

Do the earnings include commissions or bonuses? ☐ Yes ☐ No

Regular hours scheduled to work:

Was claim for Long Term Disability or Waiver of premium submitted to Hartford Life prior to date of death? ☐ Yes ☐ No

Was an LBO/Accelerated Death Benefit or Waiver of Premium claim ever approved by the prior carrier? ☐ Yes ☐ No

Note: Changes in amounts of coverage, or increases in coverage, may not apply if the employee was absent from work due to illness or injury on the effective date. Changes in amounts of coverage and increases are deferred until the employee returns to active full-time work. If the employee elected increases in coverage during the past two years, and the amount being claimed reflects the increases, attach copies of the election forms.

State name & amounts of other insurance, if any.

Mail benefit check to: The McKellan Group, Inc. How many total beneficiaries for this claim? _____	Employer Address *(No., Street, City or Town, State, Zip Code)*

PLEASE SEE REVERSE SIDE OF FORM FOR EMPLOYER CERTIFICATION

BENEFICIARY CERTIFICATION

(Note: If any beneficiary entitled to benefits is deceased, obtain official copy of Death Certificate.)

I hereby certify that the information provided by me in this Proof of Death form is true and complete to the best of my knowledge and belief, and I have read and understand the statements on the reverse side. Pursuant to IRS Form W-9, Request for Taxpayer Identification Number and Certification, I certify under penalties of perjury that the Social Security Number on this form is correct. I am not subject to IRS back-up withholding.

Name of Beneficiary	Date of Birth	Relationship to Employee	Address of Beneficiary: No. Street City or Town State/Zip Code

Signature of Beneficiary	Social Security Number

I hereby certify that the information provided by me in this Proof of Death form is true and complete to the best of my knowledge and belief, and I have read and understand the statements on the reverse side. Pursuant to IRS Form W-9, Request for Taxpayer Identification Number and Certification, I certify under penalties of perjury that the Social Security Number on this form is correct. I am not subject to IRS back-up withholding.

Name of Beneficiary	Date of Birth	Relationship to Employee	No. Street City or Town State/Zip Code

Signature of Beneficiary	Social Security Number

I hereby certify that the information provided by me in this Proof of Death form is true and complete to the best of my knowledge and belief, and I have read and understand the statements on the reverse side. Pursuant to IRS Form W-9, Request for Taxpayer Identification Number and Certification, I certify under penalties of perjury that the Social Security Number on this form is correct. I am not subject to IRS back-up withholding.

Name of Beneficiary	Date of Birth	Relationship to Employee	No. Street City or Town State/Zip Code

Signature of Beneficiary	Social Security Number

The McKellan Group, Inc. **Questions: 1-800-531-2001**
1449 Old Waterbury Rd #201 **Fax #: 203-575-0308**
Southbury, CT 06488

DOCUMENT VERIFICATION

To ensure prompt handling of this claim, please consider all of the following documents which should be included with this claim submission, where applicable.

- Certified Death Certificate
- Enrollment card
- Beneficiary Designation Form
  - If beneficiary is a minor, certified guardianship papers for the estate of the minor beneficiary must be provided.
  - If payment is to be made to an estate, certified estate papers must be submitted.
  - If payment is to be made to the estate, are you requesting a Form 712? ☐ Yes ☐ No
- Form W-2 (if benefit is based on prior years' earnings)
- Medical Authorization (if applicable)
- Family Leave Approval Form (if employee was out on family leave)

MAIL TO:

The McKellan Group, Inc. **Questions: 1-800-531-2001**
1449 Old Waterbury Rd #201 **Fax #: 203-575-0308**
Southbury, CT 06488

For residents of all states *EXCEPT* California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, Oregon, and Virginia: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** The Hartford shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

For residents of Florida: 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.

For residents of New Jersey, Arkansas, New Mexico, and Louisiana: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of 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 a person to criminal and civil penalties.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading 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 its agent who knowingly provides false, incomplete or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

FOR RESIDENTS OF 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.

EMPLOYER CERTIFICATION: ***I hereby certify that the information provided is true and complete according to the records of the Employer. I agree that this information is subject to audit by Hartford Life Insurance Company or Hartford Life and Accident Insurance Company and/or its representatives.***

Dated _____ Address _____

_____ By _____ _____
(Employer) *(Their Authorized Representative)* *(Please print)* *(Signature)*

( ) _____
(Telephone Number)