GROUP LIFE INSURANCE CLAIM PACKET
(Death)

SYMETRA
RETIREMENT | BENEFITS | LIFE

You Can Help Ensure A Quick Claim Decision

- ✓ All required claim forms must be signed, dated and completed fully and accurately.
- ✓ Provide all supporting documentation as required:
  - Original certified death certificate with cause and manner of death for non-accident claims in excess of $250,000 and for accident claims in excess of $150,000; otherwise a photocopy is acceptable.
  - All enrollment and beneficiary forms completed by the member. This would include enrollment forms completed prior to the Symetra policy.
  - Verification of Earnings as defined in your policy if claim is in excess of $100,000 and a benefit amount is based on earnings.
  - Fully complete the Policyholder's Group Life and Accidental Death Statement.

Policyholder's Instructions for Filing a Group Life and Accidental Death Claim

Please submit the following to expedite claim review:

MEMBER CLAIM

- ☑ **Policyholder's Group Life and Accidental Death Statement** fully completed by the policyholder.
- ☐ **Beneficiary Statement** fully completed by the beneficiary. If multiple beneficiaries, make additional copies for each beneficiary to complete.
- ☐ **Certified death certificate** with cause and manner of death. The original is needed for non-accident claims in excess of $250,000 and accident claims in excess of $150,000; otherwise, a photocopy is acceptable.
- ☐ **All original enrollment forms** (including forms completed prior to the Symetra policy effective date, if applicable) and **change of beneficiary** forms completed by the member. (If the named primary beneficiary has predeceased the member, provide a copy of the named beneficiary's death certificate.)
- ☐ If a benefit is based on **earnings** and the total claim is more than $100,000, provide proof of earnings as of the period specified in your policy's Earnings definition.
- ☐ If claim is being made for **Accidental Death benefits**, provide:
  - ☐ The police or accident report, newspaper articles, work injury report or similar documentation that describes the accident.
  - ☐ The Authorization for Release of Medical Information fully completed by the named beneficiary or next of kin if named beneficiary is not the next of kin.
- ☐ Review the Fraud Warning Notices for your state.

DEPENDENT CLAIM

- ☐ **Policyholder's Group Life Insurance and Accidental Death Statement** fully completed by the policyholder.
- ☐ **Beneficiary Statement** fully completed by the beneficiary.
- ☐ **Certified death certificate** with cause and manner of death. The original is needed for non-accident claims in excess of $250,000 and accident claims in excess of $150,000; otherwise, a photocopy is acceptable.
- ☐ **Copies of all enrollment forms** completed by the member (including forms completed prior to the Symetra policy effective date, if applicable).
- ☐ If claim is being made for **Accidental Death benefits**, provide:
  - ☐ The police or accident report, newspaper articles, work injury report or similar documentation that describes the accident.
  - ☐ The Authorization for Release of Medical Information fully completed by the member.
- ☐ Review the Fraud Warning Notices for your state.

Symetra reserves the right to request an original certified death certificate or verification of earnings.

Mail documents to:
Symetra Life Insurance Company
Claims Department
PO Box 1230
Enfield, CT 06083-1230

If you should need assistance in submitting the claim, please contact the Life and Absence Management Center at 1-877-377-6773 or email LADCLA@symetra.com. Additional information may be required.

Click here to clear page

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Symetra Life Insurance Company
First Symetra National Life Insurance Company of New York
Claims Department
Mailing Address: PO Box 1230 | Enfield, CT 06083
Phone 1-877-377-6773 | Fax 1-877-737-3650 | TTY/TDD 1-800-833-6388
www.symetra.com

POLICYHOLDER'S GROUP LIFE AND ACCIDENTAL DEATH STATEMENT

Group Policy Number 0101709100 Date of death _____ Cause of death _____

Was death due to an accident? ☐ Yes ☐ No If yes, date of accident (if not date of death) _____

☐ Employee claimed amount(s): Basic Life $_____ Basic Accidental Death (AD) $ _____
Supplemental Life $ _____ Supplemental AD $ _____

☐ Dependent claimed amount(s): Basic Life $ _____ Basic Accidental Death (AD) $ _____
Supplemental Life $ _____ Supplemental AD $ _____

A. INFORMATION ABOUT THE MEMBER

1. Member's name _____ Life Insurance Class _____
(This information is required. Refer to your policy.)
2. Address _____
3. Hours worked per week _____ ☐ FT ☐ PT
4. If benefit is based on Earnings, provide salary used to calculate benefit amount $_____ per ☐ hour ☐ week ☐ month ☐ year
What was the effective date of this salary _____
5. Social Security number_____ Date of birth _____
6. Occupation _____ Department/Location _____
7. Date employed _____ Effective date of coverage _____ Member premiums paid thru _____
8. If Member stopped working prior to accident date or date of death stated above,
provide date last worked_____ and reason (layoff, illness, FMLA, etc.)_____
9. Was employment terminated prior to accident date or date of death stated above? ☐ Yes ☐ No
If yes, answer the following:
Date employment terminated _____ Was waiver of premium applied for? ☐ Yes ☐ No ☐ Unknown
Was portability applied for? ☐ Yes ☐ No ☐ Unknown Was conversion applied for? ☐ Yes ☐ No ☐ Unknown

B. INFORMATION ABOUT THE DEPENDENT (Answer only for a Dependent Death)

1. Name of deceased dependent _____ Dependent SSN _____
2. Relationship to Member _____ Effective date of dependent coverage _____
3. Dependent's premium paid thru _____

C. INFORMATION ABOUT THE BENEFICIARY(IES) (If more than one beneficiary, use an additional page.)

1. Beneficiary's name _____
2. Daytime phone number _____ Date of birth _____ Sex ☐ M ☐ F
3. Address _____
4. Relationship to the deceased ☐ Spouse ☐ Child ☐ Other _____

Do you recommend payment of this claim?_____ Remarks _____

- I certify that the above member met the eligibility requirements of the policy and was insured under the policy at the time of death or accident.
- I am not a beneficiary nor am I related to the member or to a beneficiary.
- I am an authorized representative of the policyholder and confirm that the above statements are true.
- I have read the attached fraud notices.

Name of Policyholder_____

Address _____

Phone_____ Fax _____ E-mail address _____

Signature _____ Print name _____

Title _____ Date _____

Please read the following notice that we are required by law to give to you.

For all states not named: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

AL: 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.

AR, LA, RI, WV: 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.

AZ: 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.

CA: For your protection California law requires the following to appear hereon: 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.

CO: 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.

DE: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: 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.

FL: 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.

ME: 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.

MD: 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.

NH: 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.

NJ: 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.

NM: 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.

NY: The following applies to health insurance only: 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.

OK: 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.

PA: 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.

TN, VA, WA: 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.

TX: 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.

POLICYHOLDER'S FREQUENTLY ASKED QUESTIONS

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Q: What happens after the claim has been submitted?
A: The claim will be assigned to a Life Claims Specialist the day it is received. A letter acknowledging receipt of the claim is sent to the policyholder and beneficiary(ies). Within 48 hours, the claim will be reviewed. If additional information is needed to make a claim determination, it will be requested from the policyholder or the beneficiary.

Q: How long does it take for a claim to be paid?
A: Once all necessary information is obtained, payment usually takes less than five business days. Payment is sent directly to the beneficiary and written notice of the payment is sent to the policyholder.

Q: Who do I contact if I have a question about a filed claim?
A: Questions regarding claim submissions may be directed to our toll free number at 1-877-377-6773 or emailed to LADCLA@symetra.com. It is helpful if you refer to the claim number provided in the acknowledgement letter.

Q: How can I check the status of my claim?
A: Contact Symetra by phone at 1-877-377-6773 or visit www.Symetra.com/GO and log in to view your claim data if you are a registered user. If you are not a registered user, select New User Registration to begin the registration process.

Q: Can a claim be processed when the death certificate notes the Cause of Death as "Pending" or "To Be Determined"?
A: The specific cause of death must be included on the death certificate before the claim can be processed. When a death certificate does not include the specific cause of death, an amended death certificate is usually issued shortly thereafter. If there is an extended delay or difficulty in obtaining the amended death certificate, contact the Life Claims Specialist for assistance.

Q: Is the original enrollment form(s) required?
A: The original enrollment form(s) is required when the claim is for a member's death. Copies may be submitted when the claim is for a dependent's death.

Q: What do I do if an enrollment form or beneficiary form is not available?
A: Proceed with submitting the claim with the documents that you have in your possession. Provide a note with the claim explaining that you have no enrollment or beneficiary forms and why. The Life Claims Specialist will review the claim and determine the appropriate beneficiary(ies) in accordance with the policy.

Q: What happens if the beneficiary is a minor?
A: If the beneficiary is a minor child, the custodian or guardian of the child should complete the Beneficiary Statement on his or her behalf. State laws do not allow payment of a benefit directly to a minor beneficiary. Instead payment may be made to a person who is court appointed as guardian of the estate of the minor beneficiary or, depending on the state the minor beneficiary resides in and the amount of the payment, payment may be made to an adult custodian under the Uniform Transfer to Minors Act (UTMA). A third option is for Symetra to hold the proceeds in an interest bearing account until the minor beneficiary reaches legal age at which time the benefit will be paid directly to the beneficiary. The Life Claims Specialist will discuss these options with the custodian of the minor beneficiary.

Q: What happens if the beneficiary is an Estate or Trust?
A: If the beneficiary is an Estate or Trust, the executor/administrator or trustee should complete the Beneficiary Statement and provide a copy of the Estate papers or Trust agreement.

Q: Can a funeral home be paid directly?
A: Yes. If we receive a funeral home assignment signed by the beneficiary (and the beneficiary is not a minor), which identifies the Symetra policy, the funeral home can be paid directly. If there is more than one beneficiary and the intent is for the beneficiaries to share in the reimbursement of the funeral home assignment, each beneficiary must sign an assignment. The funeral home provides the assignment form.

Q: What is the effect of divorce on beneficiary designations?
A: The effect of a divorce on beneficiary designations depends on applicable state law, and on whether the group plan is subject to ERISA. In general, Symetra cannot enforce the terms of a divorce decree absent a court order directing Symetra to take specific action.

Q: Does the beneficiary designation in a will control over a beneficiary designation for the group life insurance policy?
A: No, the beneficiary designation in a will does not control over the beneficiary designation in the group life insurance policy. The beneficiary designation for the group life policy will determine the beneficiary(ies).

Q: Can a benefit payment be issued to a beneficiary residing in a foreign country?
A: Yes, we can issue payment to a foreign beneficiary. Benefits will be issued in U.S. dollars. If the beneficiary does not have a Tax Identification Number or Social Security Number, the payment may be subject to withholding tax.

Q: Are life insurance proceeds taxable?
A: Life insurance proceeds (non-living benefit) are not taxable; however, if there is interest payable on the benefit, the interest may be considered taxable income. If the interest payable on a life insurance claim totals over $600.00 an IRS 1099-INT form will be mailed to the beneficiary in January following the date the payment was made. The recipient should consult with a tax advisor for more information on the taxation of these benefits.

Q: What if the claim or payment of a benefit is denied?
A: Symetra sends an explanation letter to the beneficiary along with instructions on how to file an appeal if the beneficiary disagrees with our decision. The policyholder will receive written notice that the claim or a benefit has been denied. If we receive additional information to support the original claim, a Life Claims Specialist will re-open the claim. If no additional information has been provided to support the original claim and a reversal of the denial, the file will be assigned to an Appeals Specialist for further review.

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Symetra Life Insurance Company
First Symetra National Life Insurance Company of New York

Claims Department
Mailing Address: PO Box 1230 | Enfield, CT 06083
Phone 1-877-377-6773 | Fax 1-877-737-3650 | TTY/TDD 1-800-833-6388
www.symetra.com

BENEFICIARY STATEMENT

INSTRUCTIONS TO THE BENEFICIARY:

- Each beneficiary should complete and sign a separate Beneficiary Statement. If the beneficiary is a minor, the parent or custodian of the minor beneficiary may sign on his or her behalf.
- If claim is being made for an Accidental Death benefit, provide:
  - The police or accident report, newspaper articles, work injury report or similar documentation that describes the accident.
  - The Authorization for Release of Medical Information fully completed by the named beneficiary or next of kin if named beneficiary is not the next of kin.
- Review the Fraud Warning Notices for your state.
- Mail these documents to the address at the top of this claim form.

Group Policy Number _____

A. INFORMATION ABOUT THE DECEASED PERSON

1. Name _____
2. Date of birth _____ Date of death _____
3. Last address, if known _____

B. INFORMATION ABOUT THE DECEASED DEPENDENT (Answer only for the death of a Member's child or spouse)

1. Relationship of the deceased to the Member ☐ Spouse ☐ Child ☐ Other _____
2. If the dependent is your spouse, provide date of marriage _____
3. If the dependent is your child, answer the following:
   a. Was the dependent child attending school? ☐ Yes ☐ No
   b. If yes, ☐ full time ☐ part time Name of school _____
   c. Was the dependent child working full time? ☐ Yes ☐ No
4. If dependent was confined to a hospital since the effective date of coverage, please provide the hospital name, address and date of confinement _____

C. INFORMATION ABOUT THE BENEFICIARY

1. Beneficiary's name _____
2. Social Security number _____ Date of birth _____ Sex ☐ Male ☐ Female
3. Address _____
4. Home phone _____ Work phone _____ Cell phone _____

   ☐ Check this box if you have been notified by the Internal Revenue Service that you are subject to backup withholding on interest and dividends, under provisions of 3406(a)(1)(c) of the Internal Revenue Code.

5. Relationship to the deceased ☐ Spouse ☐ Child ☐ Other _____

D. BENEFICIARY'S SIGNATURE

I certify, under penalty of perjury, that the information I have provided in this Beneficiary Statement is true, correct, and complete to the best of my knowledge. I have read the fraud notices included with this Statement.

Signature _____ Print name _____

Date _____

Please read the following notice that we are required by law to give to you.

For all states not named: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

AL: 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.

AR, LA, RI, WV: 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.

AZ: 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.

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CO: 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.

DE: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: 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.

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MD: 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.

NH: 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.

NJ: 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.

NM: 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.

NY: The following applies to health insurance only: 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.

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Symetra Life Insurance Company
Claims Department
Mailing Address: PO Box 1230 | Enfield, CT 06083
Phone 1-877-377-6773 | Fax 1-877-737-3650 | TTY/TDD 1-800-833-6388

Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.

SYMETRA LIFE INSURANCE COMPANY

Authorization for Release of Medical Information

Group Life Policy Number: _____

Name of insured/patient (please type or print): _____ Date of birth: _____

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs, and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

This Authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, continue my coverage, or make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____
Signature of Insured/Patient or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Patient

BENEFICIARY'S FREQUENTLY ASKED QUESTIONS

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Q: How long does it take for a claim to be paid?
A: Once all necessary information is obtained, payment usually takes less than five business days. Payment is sent directly to the beneficiary.

Q. Who do I contact if I have a question about a filed claim or would like to check the status?
A: Questions regarding claim submissions may be directed to our toll free number at 1-877-377-6773 or emailed to LADCLA@symetra.com. It is helpful if you refer to the claim number provided in the acknowledgment letter.

Q: Can a claim be processed when the death certificate notes the Cause of Death as "Pending" or "To Be Determined"?
A: The specific cause of death must be included on the death certificate before the claim can be processed. When a death certificate does not include the specific cause of death, an amended death certificate is usually issued shortly thereafter. If there is an extended delay or difficulty in obtaining the amended death certificate, contact the Life Claims Specialist for assistance.

Q: What happens if the beneficiary is a minor?
A: If the beneficiary is a minor child, the custodian or guardian of the child should complete the Beneficiary Statement on his or her behalf. State laws do not allow payment of a benefit directly to a minor beneficiary. Instead payment may be made to a person who is court appointed as guardian of the estate of the minor beneficiary or, depending on the state the minor beneficiary resides in and the amount of the payment, payment may be made to an adult custodian under the Uniform Transfer to Minors Act (UTMA). A third option is for Symetra to hold the proceeds in an interest bearing account until the minor beneficiary reaches legal age at which time the benefit will be paid directly to the beneficiary. The Life Claims Specialist will discuss these options with the custodian of the minor beneficiary.

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