Life Insurance Claim Form

Claims Department
17900 N. Laurel Park Dr.
Livonia, MI 48152-3985
(800) 624-1662

Certificate/Claim/Policy #:

Instructions for Filing a Claim

Complete all parts of this claim form as required.

Additional documentation may be requested as necessary for the evaluation of this claim.
If you have any questions, please call our Claims Department toll-free at 1-800-624-1662 and follow the prompts for Claims.

Acceptance of this form is not an admission of liability under the certificate/policy.

Send this Claim Form to:

AAA Life Insurance Company
Claims Department
17900 N. Laurel Park Dr.
Livonia, MI 48152-3985
(800) 624-1662

Payment of Claims Authorization

I declare that all my statements are true and complete, and that, to the best of my knowledge and belief, I have withheld no relevant facts from the Company.

The undersigned agrees to indemnify and hold AAA Life Insurance Company harmless from any and all costs, actions, losses, or damages, which it may suffer by virtue of payment of any proceeds under the policies/certificates, described herein. The undersigned agrees to join in any litigation concerning the payment of said proceeds and furnish further proofs, if requested. AAA Life Insurance Company and its agents do not provide legal or tax advice. You should always seek competent tax and legal advice. I have read and initialed the applicable fraud warning attached to this form.

I am: ◯ US Citizen ◯ Resident Alien ◯ Non-Resident Alien

Name of claimant/legal representative (please print):	**Signature of claimant/legal representative:**		
Social Security Number:	**Date:**	Daytime telephone number:	
Address:	City:	State:	Zip code:

Representative/Attorney's Authorization

If a representative/attorney will be handling this claim on your behalf, please complete this section.

I give authorization to my representative/attorney to represent me in all manners regarding this claim.
If benefits are approved:

◯ The check is to be made payable in my name, however, mailed to my representative/attorney.

◯ The check is to be mailed directly to me.

Claimant's Signature:		**Date:**	
Representative/Attorney's name: (please print)		Representative/Attorney's phone number:	
Representative/Attorney's Address:	City:	State:	Zip code:

PART 1

Claimant's Statement

Please Print

1a) Name of deceased insured:	1b) Also known as:
2) Date of birth:	3) Date of Death:
4a) Name of Claimant/Legal Representative:	6) Relationship:

7) Name of surviving spouse/partner:

8) List all children of the deceased, including stepchildren and adopted children. Please use Comment Section if additional space is needed.

Name	Date of Birth	Address

PART 2

Complete Part 2 if this policy is in the "contestable period".
A policy is in the "contestable period" if it has been in force or reinstated for less than two (2) years.

9) List any policies the deceased held with this company (indicate all policy number):

10) List other policies the deceased held with other companies:
Please use Comment Section if additional space is needed.

Policy 1	Name of Company:	**Policy 2**	Name of Company:
	Insurance Amount:		Insurance Amount:
Policy 3	Name of Company:	**Policy 4**	Name of Company:
	Insurance Amount:		Insurance Amount:

11) When did the deceased first complain or give other indication of last illness?

12a) When did the deceased first consult a physician for the last illness?

12b) Name & address of physician:

Certificate/Claim/Policy #: _____

PART 3

Unless advised otherwise, payments under a settlement option will begin upon receipt of this form.

PAYMENT IS TO BE MADE IN THE FOLLOWING MANNER
(Refer to settlement options of the policy/certificate for full description)

◯ Lump Sum

If policy/certificate language provides for payment of the death claim benefits in manner other than lump sum, you may choose:

◯ Annual ◯ Semi-Annual ◯ Quarterly ◯ Monthly Payment for a fixed number of _____ years.

◯ Lifetime Income _____ years certain.

◯ Lifetime Income jointly to payees. ◯ Other. Please describe: _____.

☐ Please direct deposit any payment(s) to my ◯ Checking account **or** ◯ Savings account

Account Holder Name _____

Routing Number _____

Account Number _____

PART 4

Substitute W-4P

Withholding Election (Form W-4P /OMB No. 1545-0415)

Please read the entire section of the withholding notice. Complete for any distribution.

Generally life insurance benefits are not taxable, however there are some exceptions. Please seek competent tax advice before completing.

☐ **I elect not to have Federal income tax withheld.**

☐ **I elect not to have State income tax withheld.**

I understand that I am still liable for the payment of any Federal and State income tax that may be due on the amount of gain received. I also understand that I may be subject to Federal and State income tax penalties under the estimated tax payment rules, if my payments of the estimated tax and withholding are insufficient.

☐ Withhold Federal income tax at a rate of _____ % (not less than 10%) or $ _____ of the taxable distribution.

☐ Withhold State income tax at a rate of _____% from any taxable distribution.

Please consult your tax advisor if you have any questions about Federal or State tax withholding.

Claimant's Signature _____ Date _____

PART 5

Authorization to Release Confidential Medical Information

The purpose of this disclosure is to evaluate this claim for benefits. The undersigned understands that the furnishing of forms by the AAA Life Insurance Company ("Company") does not constitute an admission of liability. I authorize any licensed physician, medical practitioner, hospital (including veterans' hospitals), clinic, pharmacy, pharmacy benefit manager or other medical-related facility, insurance company, the Medical Information Bureau ("MIB"), or other organization that has any records or knowledge of medical or prescription history about _____ to give any such information to the Company, its reinsurer(s) or any agency
(Name of Insured)
employed by the Company to collect and transmit such information. Such information is to include, but is not limited to, any and all records and information regarding diagnosis, testing, treatment, prescriptions, and prognosis of the Insured's physical or mental condition. The Company will not use or disclose medical information for any other purposes other than stated, except as may be required by law. Such medical information may be subject to re-disclosure and may no longer be protected by federal privacy regulations. I understand I have the right to revoke this authorization in writing to the Company; however, if I do, the Company may be unable to complete the evaluation of the claim for benefits. This Authorization will remain in effect for a maximum of twelve (12) months from the date of my signature below. A photocopy of this Authorization will be treated in the same manner as the original.

Signature: _____ Date: _____

Comment Section

PART 6

FRAUD WARNINGS

Please read the fraud warning for the state of issue of the policy/certificate.
Write your initials in the box provided next to the appropriate state.

☐ **State not listed below:** Any person who, with the intent to defraud or knowing that 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.

☐ **Alaska:** A person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

☐ **Arizona:** 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 or civil penalties.

☐ **Arkansas:** 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.

☐ **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.

☐ **Colorado:** 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.

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

☐ **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:** 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.

☐ **Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

☐ **Indiana:** A person who knowingly, and with intent to defraud an insurer, files a statement of claim containing any false, incomplete, or misleading information commits a felony.

☐ **Kentucky:** 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.

PART 6

☐ **Louisiana:** 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.

☐ **Maine:** 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.

☐ **Minnesota:** A person who files a claim with intent to defraud, or helps commit a fraud against an insurer, is guilty of a crime.

☐ **New Hampshire:** 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:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

☐ **New Mexico:** 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:** Any person who, with intent to defraud or knowing that he/she 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.

☐ **Oklahoma:** 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.

☐ **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 such person to civil and criminal penalties.

☐ **Tennessee:** 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:** 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.

☐ **West Virginia:** 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.

☐ **Washington:** 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.