UnitedHealthcare®

**CRITICAL LIFE SAFEGUARD: TERM LIFE -LIFE INSURANCE CLAIM FORM**
**Golden Rule Insurance Company**
**UnitedHealthcare Life Insurance Company**

## Instructions for Filing Your Claim:

1. Fill out this form completely. Failure to do so could result in a delay in processing this claim.
2. Include a certified copy of the Death Certificate, a copy of the obituary and a copy of the police report (if applicable).
   **NOTE:** A certified copy of the Death Certificate must be mailed. Faxed copies will not be accepted.

**Mail or fax all forms and documents to:** **Claims Department**
**PO Box 31374**
**Salt Lake City, UT 84131-0374**

**Fax to: 1-801-478-7581**

If there are any questions about what benefits are covered or how to use this form, please contact our customer service department at **1-800-657-8205**, or refer to your plan documents.

### PART 1: PRIMARY INSURED INFORMATION

| | | | |
|---|---|---|---|
| Primary Insured Name: | | Policy Number: | |
| Address: | City: | State: | ZIP Code: |
| Daytime Phone Number: | | | |

### PART 2: DECEASED PERSON INFORMATION

*Submit certified copy of Death Certificate, a copy of the obituary and a copy of the police report (if any).*

| | | | |
|---|---|---|---|
| Deceased Person's Name: | | Date of Birth: | |
| Last Legal Residence: | City: | State: | ZIP Code: |
| Date of Death: | Cause of Death: | | |
| Relationship to Insured: | | | |

### PART 3: BENEFICIARY INFORMATION *(Attach a separate sheet if necessary.)*

| | | | |
|---|---|---|---|
| Beneficiary Name *(Please Print)*: | | Date of Birth: | |
| Beneficiary Address: | City: | State: | ZIP Code: |
| Beneficiary Phone Number: | Relationship to Deceased: | | |
| If you are not the beneficiary, in what capacity do you make this claim: | | | |

| | | | |
|---|---|---|---|
| Beneficiary Name *(Please Print)*: | | Date of Birth: | |
| Beneficiary Address: | City: | State: | ZIP Code: |
| Beneficiary Phone Number: | Relationship to Deceased: | | |
| If you are not the beneficiary, in what capacity do you make this claim: | | | |

I verify that all information contained in this form is true, correct, and complete to the best of my knowledge.

**Warning:** Any person who knowingly and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing false, incomplete, or misleading information may be guilty of a crime and may be prosecuted under state law. Penalties may include imprisonment, fines, and denial of insurance benefits.

**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.

**Warning:** For your protection **Florida** law requires the following statement to appear on this form. 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.

| | | | |
|---|---|---|---|
| _____ | X | _____ | _____ |
| Beneficiary or Other Claimant *(Please print)* | | Signature of Beneficiary or Other Claimant | Date |
| _____ | X | _____ | _____ |
| Beneficiary or Other Claimant *(Please print)* | | Signature of Beneficiary or Other Claimant | Date |
| _____ | X | _____ | _____ |
| Legal Guardian *(if applicable) (Please print)* | | Signature of Legal Guardian *(if applicable)* | Date |
| _____ | X | _____ | _____ |
| Witness *(Please print)* | | Signature of Witness | Date |