



Loss Of Life Beneficiary Statement

- A.** When submitting a claim for benefits due to loss of life, submit the following with this completed form:
1. **Certified copy of the death certificate.**
 2. If death was due to accident, a copy of the **coroner's report, accident report** and newspaper clippings.
- B.** If the beneficiary is:
1. A minor or incompetent - If a guardian has been appointed, submit a certified copy of the appointment of the guardian of the estate of the minor or incompetent. If no guardian has been appointed, furnish full name and address of person who has custody of the minor or incompetent.
 2. An Estate - Submit a certified copy of the appointment of the Executor or Administrator. If estate is not to be probated furnish name, address and relationship of next-of-kin.
 3. Deceased - Submit a certified copy of the beneficiary's Death Certificate.

Section 1: Information about the deceased insured

Full name of insured as it appears on the policy		Policy number(s)	Insurance Amount
Complete Address		Date of Birth	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
Occupation at time of death	Date of death	Place of death	
Cause of death			
If death was due to an accident, provide details of the accident			Date of accident
If death was due to an illness, when did the deceased first give indication of the illness?		-first consult a physician for the illness?	

Section 2: Authorization and Beneficiary Information

I hereby authorize and request that Allstate Health Solutions or its representatives be provided with any and all facts, dates, and copies of records concerning the history and physical and mental records of the deceased.

I UNDERSTAND the information obtained by use of this authorization will be used by Allstate Health Solutions or its representative to determine eligibility benefits under existing coverage. Any information obtained will not be released by Allstate Health Solutions or its representative to any person or organization **EXCEPT** to reinsuring companies, or other persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required, or as I may further authorize.

I KNOW that I may request a copy of this Authorization. **I AGREE** that a Photocopy/Fax/E-mail copy of this document shall be as valid as the original. **I AGREE** this Authorization shall be valid for the period required to process the claim.

Signed at _____ this _____ day of _____ 20____
City, State Day Month Year

Beneficiary Signature (Parent Or Guardian Must Sign For A Minor)	Witness Signature		
Print Beneficiary's Name	Date of Birth	Social Security No.	Phone No.
Address	City	State	Zip

Mail to:
Allstate Health Solutions
PO Box 3252
Milwaukee, WI 53201-3252

If you have questions about this form, please call (855) 232-4750.

FRAUD WARNING NOTICES:

For states not listed below: 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 subject such person to criminal and civil penalties.

Alabama: 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.

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 false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, District of Columbia, Rhode Island & West Virginia: Warning - 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.

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, Idaho & Oklahoma: Warning - 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.

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.

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

Kentucky: A 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.

Maryland: 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.

Maine, Tennessee & 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 may include imprisonment, fines or a denial of insurance benefits.

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.

Texas: 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.