Nippon Life Benefits®

Nippon Life Insurance Company of America
P.O. Box 2312
Mt. Clemens, MI 48046
claims-lifeanddisability@nipponlifebenefits.com
Phone: 1-800-374-1835
FAX 847-615-3122

Group Life Claim

Instructions to Beneficiary

(Use this form for both member and dependent claims.)

Please mail or FAX this completed form to the address or FAX number above. Please call 800-374-1835 with questions on how to complete this form.

(1) Complete Part II and Part III of the form.

The following information may help you.

More than one beneficiary – If more than one beneficiary is named, each beneficiary needs to complete a claim form.

Member's estate as beneficiary; minor/incompetent beneficiary; predeceased beneficiary - If the life benefit is determined to be due and payable to any of these beneficiaries, there may be additional information required in order to release the benefit. A company representative will contact you to request information when appropriate.

Additional information - Nippon Life Benefits reserves the right to require and obtain such statements, authorizations and other information as it deems necessary to determine what benefits are payable on any claim.

(2) Complete Part IV on the form.

(3) If accidental death/personal loss benefits are being claimed, the following information may be needed. Please provide any of these documents you may already have:

- Incident Report
- Autopsy/toxicology reports
- Newspaper clippings
- Investigating police department and contact name and phone number
- If member's death occurs more than 100 miles from permanent place of residence and costs are incurred for preparation and transportation of the body, please enclose a copy of the associated expenses.
- The policy may provide additional accidental death/personal loss benefits if the member has "Qualified Students." A "Qualified Student" is a dependent child who is, at the time of death, a full-time student at an accredited post-secondary school or a 12th grade student if he/she enrolls in an accredited post-secondary school within 12 months of death. If there is a "Qualified Student," please call the 800 number listed above to determine if additional benefits are applicable and to obtain the necessary form to apply for this benefit. (This benefit not approved in some states.)
- Complete attached authorization page and return with the other documents requested.

(4) Attach a certified copy of the deceased member's (dependent's) death certificate. If the death occurred outside the United States, attach a copy of document entitled "Death of an American Citizen" from the U.S. Embassy.

(5) Return the completed form and death certificate to the group planholder.

Instructions to Group Planholder

(1) Complete Part I of this form accurately and completely to avoid any delays in payment of the benefits.

NOTE - If more than one beneficiary is named, you must provide a form to each beneficiary for completion of Part II and Part III of the form. You need not complete Part I on all the forms. If possible, please submit all claim forms at the same time.

(2) Return the completed form(s) and any other information you may have, such as:
(a) enrollment forms, (b) change of beneficiary forms, (c) assignments, (d) settlement instructions to:

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Life Claim Information

GROUP PLANHOLDER: please return to Nippon Life Benefits

Part I: Information about the Group Planholder

Member's name (Please list all names member may have been known by such as maiden name, nickname or alias)	Member's I.D.

If dependent death, name	Relationship to member

Member's job title	Member's classification in policy	Salary	Effective date of salary
		$	

Effective date of member's coverage	Date member began employment	Number of hours worked per week	Date member was last actively at work

Reason member ceased active work:
☐ death ☐ retired ☐ illness or injury ☐ terminated ☐ other (explain) ______

Were premiums paid through date of death? ☐ yes ☐ no

If dependent claim, was member working at the time of death? ☐ yes ☐ no

If no, what was the date last worked? ______ If dependent, is member still working? ☐ yes ☐ no

Did the member name more than one beneficiary? ☐ yes ☐ no If yes, are all claim forms attached? ☐ yes ☐ no

Amount of benefit claimed
$

Employer name	Policy number	Unit/division number

Signature of planholder ▶	Title	Date

If we have questions, your phone number is	FAX number

Part II: Information about the Deceased

Deceased's name

Address – street	City	State	ZIP

Date of birth	Date of death	Social security number

Are you making claim to any accidental death/personal loss benefit provided by the policy? ☐ yes ☐ no
If yes, please send us any newspaper articles, accident reports, or other documentation that would provide us with information about the death.

Was dependent employed? ☐ yes ☐ no If yes, please give employer's name, phone number and date last worked.

______

Part III: Information about the Beneficiary

Your name (beneficiary)	Date of birth

Your address – street	City	State	ZIP

Your phone number – home	Your phone number - work

You are making claim to: ☐ all of the proceeds on the deceased's claim.
☐ only the portion due me as one of the beneficiaries of the member.

Your relationship to member: ☐ spouse ☐ child ☐ other (explain) ______

IV. Request for Taxpayor's Social Security Number or Tax Identification and Certification.

If the social security number or tax identification number of the beneficiary is not supplied, the beneficiary may be subject to federal and state tax withholding. I have provided the appropriate social security or tax identification number below:

☐ The benefits are being claimed by me as a beneficiary and my social security number is ______________________

☐ The benefits are being claimed by the legal guardian of a minor/incompetent person's estate.
The minor/incompetent person's social security number is ______________________

☐ The benefits are being claimed by a trustee of a trust or a personal representative of an estate.
The tax identification number for the trust or estate is ______________________

The information provided by me on this claim form is true and complete to the best of my knowledge. Under penalty of perjury I certify that the social security number or tax identification number supplied on this form is true, correct, and complete.

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.

Date	Signature of beneficiary (Please make sure your sign form as your name appears on your social security card.)
	▶

Certification of Foreign Status (For Foreign Entities Only)

Under penalties of perjury, I certify that for interest payments, I am not a U.S. citizen or resident (or I am filing for a foreign corporation, partnership, estate, or trust).

U.S. taxpayer's identification number (if any)	Country of citizenship
☐ SSN ☐ ITIN ☐ EIN	

Permanent address

Date	Signature
	▶

Notice Requirements

Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form 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. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

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 and civil penalties.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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.

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.

Notice Requirements

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.

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.

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

Ohio: Any person who, with intent to defraud or knowing that he or 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 criminal and civil penalties.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

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.

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.

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Group Life Authorization for Release of Personal Health and Other Information to Nippon Life Benefits

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, emergency care provider, health care provider, health plan and its administrator, disability plan and its administrator, insurer, or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, or coverage to the deceased insured to disclose the entire medical, accident, and medical examiner records to Nippon Life Benefits, its agents, employees, insurance support organizations, reinsurers, and their representatives. This includes information on the diagnosis and treatment of mental illness (excluding psychotherapy notes as defined under HIPAA) and the use of alcohol, drugs, and tobacco.

I understand personal health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by Nippon Life Benefits. Protected health information also includes but is not limited to: hospital records, treatment records/office notes, alcohol or drug abuse treatment, consultation reports, workers' compensation information, diagnosis, prescriptions, test results, vocational testing/counseling information, benefit information, claims information, accident information, demographic information, and claims payment information.

I understand that unless prohibited by state or federal law the protected health information is to be disclosed under this authorization so that Nippon Life Benefits may administer claims and determine or fulfill responsibility for coverage and provision of benefits, coordinate the provision of benefits under medical, life, and disability coverages, and conduct other legally permissible activities that relate to any coverage with Nippon Life Benefits.

Also, I authorize the Internal Revenue Service, Social Security Administration, any state taxing authority and any employer, former employer, business associate or partners, insurance company, insurance support organization, Worker's Compensation or vocational or rehabilitation counselor or provider to give any information or record it has about the deceased insured's employment, employment history or income to Nippon Life Benefits.

The following groups of persons employed or working for Nippon Life Benefits may use personal health and other information which is described above: employees of the claim or legal departments and any other personnel of Nippon Life Benefits, and its authorized representatives, and business associates that perform functions or services that pertain to any coverage with Nippon Life Benefits. This includes, reinsuring companies, persons or organizations performing business, legal or medical services related to the policy or claim, employer or former employer as needed to perform fiduciary responsibility under any benefit plan and, when required by law, to any other public or private entity or person.

I understand any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure. 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 at any time. The request for revocation must be in writing and sent to: Life/Disability Claims, Life and Health Segment, Nippon Life Benefits, P.O. Box 2312, Mt. Clemens, MI 48046. I understand that a revocation is not effective if Nippon Life Benefits has relied on the protected health information disclosed to it or has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that if I refuse to sign this authorization to release complete medical, accident or medical examiner records, Nippon Life Benefits may not be able to process the application for life or disability coverage, or if coverage has been issued, may not be able to make any such benefit payments. Upon your request, a copy of this completed authorization will be provided to you. Any alteration of this form will not be accepted.

Deceased's name: ______________________ **Deceased's date of birth:** ______________

Representative's signature: ______________________ **Date:** ______________

Representative's full name: ______________________ **Date of birth:** ______________

Representative's address: ______________________________________

Representative's telephone number: ______________________

Can confidential messages be left at this number? ☐ yes ☐ no

Representative's relationship to the deceased: ______________________

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