UFCW TRUST
Working For Your Benefit

UFCW & Employers Benefit Trust Fund
LIFE & ACCIDENTAL DEATH CLAIM FORM

EMPLOYEE INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Social Security #: _____

DECEASED INFORMATION (SELECT EMPLOYEE OR DEPENDENT AND COMPLETE THE RELEVANT SECTION)

☐ Employee Deceased

Date of Death: _____ (MM/DD/YYYY) Date of Birth: _____ (MM/DD/YYYY)

Last Date Worked: _____ (MM/DD/YYYY) Name of Last Employer: _____

☐ Dependent Deceased

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Death: _____ (MM/DD/YYYY) Date of Birth: _____ (MM/DD/YYYY)

Relation to Employee:

- ☐ Spouse — *[Required Documentation: Copy of Marriage Certificate]*
- ☐ Domestic Partner — *[Required Documentation: RDP Certificate]*
- ☐ Child — *[Required Documentation: Copy of Birth Certificate]*
- ☐ Other: _____

CLAIMANT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Social Security #: _____ Date of Birth: _____ (MM/DD/YYYY) Phone #: _____

Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

Under penalty of perjury, I hereby certify that the above information was correct upon the deceased's death.

X _____ (CLAIMANT'S SIGNATURE) _____ (MM/DD/YYYY)

Please Read: No benefits will be paid if the claim is received by the Trust Fund Office more than one year after the Member or Dependent's death.

REQUIRED ATTACHMENTS FOR ALL CLAIMS:

CERTIFIED COPY OF THE DEATH CERTIFICATE

AND

PRUDENTIAL BENEFICIARY STATEMENT (ENCLOSED)

PLEASE COMPLETE AND RETURN TO: UFCW & EMPLOYERS TRUST, P.O. BOX 4100, Concord, CA 94524-4100

Prudential

Beneficiary Statement

Each beneficiary should complete Sections 1, 2, and 3. If Accidental Death or Business Travel Accident benefits are being claimed, Section 4 should also be completed.

1 Deceased's Information

First Name | MI | Last Name

Social Security Number

2 Beneficiary's Information

First Name | MI | Last Name

Street | Suite

City | State | ZIP Code

Telephone Number | Date of Birth (MM DD YYYY)

3 Taxpayer Identification Number and Certification

Prudential requires your Taxpayer Identification Number. The Taxpayer Identification Number is either the Social Security Number or the Employer Identification Number. If you:

- are an individual, your Taxpayer Identification Number is the Social Security Number.
- represent a trust or estate, the Taxpayer Identification Number is its Employer Identification Number.
- represent a minor, please provide the minor's Social Security Number.
- are applying for a Taxpayer Identification Number, please write "applied for" in the space provided.

TAXPAYER IDENTIFICATION NUMBER/FORM W-9 CERTIFICATION:
Under penalties of perjury, I certify that the number shown on this form is my correct Taxpayer Identification Number (Social Security Number). I further certify that the citizen/residency status I have listed on this form is my correct citizen/residency status. I am not subject to backup withholding because (a) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding, (b) the IRS has told me that I am no longer subject to a backup withholding order, or (c) I am exempt from backup withholding.

Social Security Number or Taxpayer Identification Number of beneficiary

Check here only if you are subject to backup withholding:

☐ **I have been notified by the Internal Revenue Service that I am subject to backup withholding due to underreporting of interest or dividends.**

☐ **I am not a U.S. person (including resident alien). I am a citizen of**
(Attach completed IRS Form W-8BEN, if applicable)

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

X
Signature

Date (MM DD YYYY)

Prudential

Deceased's Social Security Number

Beneficiary Statement

If filing for an Accidental Death or Business Travel Accident claim, please complete Section 4 below.

4

Authorization for Release of Information to Prudential Insurance Company

This Authorization is intended to comply with the HIPAA Privacy Rule

Name of Insured:

First Name | MI | Last Name

Date of Birth (MM DD YYYY)

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment or services pertaining to:

First Name | MI | Last Name

Print Name of Deceased or Patient

or on my (his/her) behalf ("My Providers") to disclose my (his/her) entire medical record for me or my dependents and any other health information concerning me (him/her) to the Prudential Insurance Company of America (Prudential) and its agents, employees, and 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 and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize all non-health organizations, any insurance company, employer, or other person or institutions to provide any information, data or records relating to credit, financial, earnings, travel, activities or employment history to Prudential.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I (he/she) have made to restrict my (his/her) protected health information do not apply to this authorization and I instruct My Providers to release and disclose my (his/her) entire medical record without restriction.

This information is to be disclosed under this Authorization so that Prudential may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits, 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I (he/she) have (has) or have (has) applied for with Prudential.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. 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 sending a written request for revocation to Prudential at: P.O. Box 8517, Philadelphia, PA 19176. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my (his/her) complete medical record, Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this authorization.

*Limits, if any:

Date (MM DD YYYY)

X

Signature of Insured/Patient or Personal Representative

Description of Personal Representative's Authority or Relationship to Patient

NOTICE TO MONTANA RESIDENTS: You or your authorized representative are entitled to receive a copy of this Authorization, and upon request, a record of any subsequent disclosures of personal or privileged information.

For residents of all states except District of Columbia, Florida, Kentucky, New Jersey, New York, Pennsylvania, Virginia and Washington; WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

DISTRICT OF COLUMBIA RESIDENTS—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.

FLORIDA RESIDENTS—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.

KENTUCKY RESIDENTS—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.

NEW JERSEY RESIDENTS—Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW YORK RESIDENTS—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. This notice ONLY applies to accident coverage.

PENNSYLVANIA RESIDENTS—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 material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

VIRGINIA RESIDENTS—Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

WASHINGTON RESIDENTS—Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

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IMPORTANT INFORMATION

Illinois—If payment on certain claims is made after 15 days from the day we receive proof of death of the insured, life insurance death benefits payment under policies issued in Illinois will include interest at the rate of 9% per year. The interest will be payable from the date of death to the date of payment.

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