Catholic Association Of Foresters
Standing strong to protect you and your family.

220 Forbes Rd. Suite 205 T 781-848-8221
Braintree, MA 02184 T 800-282-2263

Statement of Claim for Death Benefits

On behalf of the Catholic Association of Foresters, please accept our condolences for your loss. Please know that we will make every effort to process your claim promptly. To ensure a timely handling of your claim, it is important that your submission contain all necessary information requested and be clearly written.

If the death occurred **after the first two years of the date of issue of the certificate**, review the following checklist prior to submitting your claim:

___ Complete Section 1 and Section 4 and sign where required. If there is more than one claimant, please ensure that a separate Claimant's Statement (Section 4) is completed by each claimant. Copies can be made of this document.
___ Obtain a certified decedent's death certificate. Only one death certificate is required, even if the decedent had multiple policies with us. Death certificates become part of the claim file and will not be returned unless specifically requested.
___ If a beneficiary has passed, provide a copy of the beneficiary's death certificate.
___ If the Claimant's name has changed, provide legal documentation supporting the name change.
___ If the claim form is to be completed by an Executor, Administrator or a Legal Guardian, a copy of the filed document supporting that appointment must be submitted with the Claimant's Statement.
___ If the claim form is to be completed by a Trustee, include the Tax I.D. of the trust or the Social Security Number of the Trustee. Additionally, provide a copy of the trust.

If the death occurred **within the first two years of the issue** of this certificate, this **claim is considered contestable**. **Review the checklist above as well as the following prior to submitting your claim:**

___ Complete all sections of this document and sign where required. If there is more than one claimant, please ensure that a separate Claimant's Statement (Section 4) is completed by each claimant. Copies can be made of this document.
___ Complete the enclosed Authorization for Disclosure of Medical and health Related Information.
___ Complete the Affidavit for the Release of Medical Records.
___ **If the death occurred from an accident, suicide, or homicide:** If the cause of death is other than natural, in addition to the Authorization and completed Claimant's Statement, submit a copy of the police report, coroner's report and/or toxicology report, along with a copy of the decedent's driver's license and any other relevant information that may help us complete our investigation. Further investigation will be made to confirm the circumstances surrounding the death.
___ **If the death occurred outside the United States or Canada:** Submit the official death certificate issued in the country where the death occurred. If available, include a notarized translation of the death certificate. Also complete the enclosed Foreign Death Questionnaire and submit a copy of the passport. In addition, if the decedent was a U.S. Citizen, we will need:
- A completed Report of the Death of an American Citizen Abroad (may be obtained from the local US Embassy or Consulate)
- A Physician's Statement, completed and signed by the doctor who certified the death.

Please understand your claim may be delayed if incomplete forms are submitted or if additional information is required by us. We will contract you as soon as reasonably possible in the event additional information is needed. Please print clearly.

Section 1: List all certificate number(s) being claimed.

a)_____ b)_____ c)_____ d)_____

Section 2: Decedent Information

Deceased Name: _____
First Middle Last

Address: _____
Street City State Zip Code

How Long in State: _____ Date of Birth: _____ Date of Death: _____

Cause of Death (provide details if death is a result of an accident, suicide, or homicide): _____
_____

To the best of your knowledge, had the deceased ever used nicotine products or had alcohol or drug abuse?
☐ Yes ☐ No ☐ Unknown

If Yes, provide detail (type, date last used, etc.): _____
_____

Section 3: Medical Information

Provide the name and address of the primary treating physician or medical facility where the deceased was treated during the past 5 years.

Name of Physician/Facility: _____

Address: _____
Street City State Zip Code

Dates of Treatment: From _____ To _____

Reason(s) for Treatment: _____

Name of Physician/Facility: _____

Address: _____
Street City State Zip Code

Dates of Treatment: From _____ To _____

Reason(s) for Treatment: _____

If additional space is required, attach separate sheet and sign and date.

Section 4: Claimant's Statement

Name: _____
First Middle Last

Address: _____
Street City State Zip Code

Relationship to Deceased: _____ Date of Birth: _____ *SSN: _____

Telephone Number: _____ Email Address: _____

*Should be provided as it may be required for reporting any taxable income paid to the claimant. If the claimant has never been assigned a number, insert "No Number". If the estate of the deceased is the claimant, the deceased's social security number/Tax I.D. should be filled in. If not provided, the certificate(s) may be subject to federal and state withholding.

Under penalties of perjury, I certify that:

- The taxpayer ID or Social Security number shown on this form is my correct taxpayer identification number
- I am not subject to backup withholding due to failure to report interest and dividend income
- I am a US Citizen (including a US resident alien)

You may cross out any of the above items that do not apply to you.

NOTE: Any person who includes any false or misleading information on an application for an insurance policy may be subject to criminal and civil penalties.

Certification (Notarization not required)

I certify that the above answers are full and true to the best of my knowledge and belief. I have read the applicable fraud warning above.

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

You can read our Privacy Statement at CatholicForesters.org.

_____ _____ _____
Claimant Name (Print) Claimant Signature Date

_____ _____ _____
Witness Name (Print) Witness Signature Date

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Authorization for Disclosure of Medical and Health Related Information

This authorization meets the requirements under the Health Insurance Portability and Accountability Act (HIPAA).

Decedent Information

Name: _____

Date of Birth: _____ SSN: _____

Address: _____City: _____State: _____Zip Code:_____

Office Use – Do not complete

I authorize the following to disclose the decedent's protected health information:

Person/Organization Name: _____

Address: _____City: _____State: _____Zip Code:_____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager, prescription drug database, government agency including the Veterans and Social Security Administrations, or other health care provider that has provided treatment or services to me or on my behalf ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") concerning me to the CATHOLIC ASSOCIATION OF FORESTERS, its agents, employees, reinsurers, and their 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 to bacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPPA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to the Representative. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical financial records will be held in confidence and may be used only for the purpose of administering claims, determining or fulfilling responsibility for provision of benefits, and conducting other legally permissible activities that relate to any coverage with the Catholic Association of Foresters. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications and claims.

This authorization shall be valid for thirty (30) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to the Representative to revoke this authorization and that the revocation will take effect when the Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand that, to the extent that other law allows an insurance company to contest a claim under an insurance policy or the insurance policy itself, my revocation of this authorization may not be effective.

_____ _____

Signature of Beneficiary or Legal Representative Date Signature of Witness Date

_____

Signature of Informant on Death Certificate Date

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Affidavit for the Release of Medical Records

Certificate Number(s): _____

_____ Passed away on _____
Name of Member Date (Month, Day, Year)

I, _____, am his/her _____,
Name Relationship

and the primary beneficiary. I state:

- That no Personal Representative has been appointed for the decedent's estate in this state or elsewhere and no application for such an appointment is pending in this state or elsewhere.
- That I am the person entitled to preference in appointment.
- That this affidavit is made in support of the undersigned request for the release of medical records for:

Name: _____

Address: _____
Address City State Zip Code

Date of Birth: _____Social Security Number: _____

I declare under penalty of perjury under the laws of the state that the foregoing is true and correct.

Dated: _____ Signature: _____

Subscribed and sworn to before me: _____

A Notary Public on _____
Date Please attach Notary Stamp