**National Union Fire Ins Co of Pittsburgh**

**AIU Holdings**
**A&H Claims Department**
**P. O. Box 25987**
**Shawnee Mission, KS 66225**
**800-617-2836 Customer Service 302-661-8959 Fax**

**PROOF OF LOSS - ACCIDENTAL DEATH**

| | |
|---|---|
| **NAME OF GROUP:** | **National Association for the Self-Employed (NASE)** |
| **POLICY NUMBER:** | **SRG 9111245** |

## ADMINISTRATOR INSTRUCTIONS

In order to assure prompt processing of this claim, please forward the claim form to the Beneficiary. Due to recent changes in tax laws, the Beneficiary will be required to complete PART B. Be certain that PART C on the reverse side is completed in full and signed by the Beneficiary.

Return this form to the above address.

In addition to the claim form, the following items are required:
(1) A Certified Copy of the final death certificate;
(2) The Police Report, any Autopsy Report, and any newspaper clippings.
(3) For Dependent Child claims – proof of enrollment from school for child attending college.
(4) A UB92 or UB04 from the hospital if admitted.

Every question must be fully answered. We reserve the right to require or to obtain further information should it be deemed necessary. If there is more than one beneficiary, all may join in one statement, or a separate form will be furnished for each if desired.

## PART A: ASSOCIATION/MEMBER INFORMATION

ASSOCIATION

| MEMBER NAME | MEMBER ID # |
|---|---|
| MEMBER ADDRESS | DATE OF BIRTH |

| DATE OF DEATH | SOCIAL SECURITY NUMBER |
|---|---|

### If Claim is For Dependent, Provide the Following:

| DEPENDENT'S NAME AND ADDRESS | SOCIAL SECURITY NUMBER | RELATIONSHIP |
|---|---|---|
| DEPENDENT'S OCCUPATION | DEPENDENT'S DATE OF BIRTH | |

## PART B: IMPORTANT TAX INFORMATION

**To Be Completed by Beneficiary**
Social Security Number/
Tax ID Number

**Please Print or Type Name of Beneficiary**

Under penalties of perjury, I certify: (1) that the Social Security/Tax ID Number shown above is my correct Social Security or Taxpayer Identification Number.

**Be Certain Part C on the Reverse Side is Completed**

## PART C: BENEFICIARY INFORMATION

In order to assure prompt processing, the authorization below must signed by the beneficiary.

| NAME OF BENEFICIARY | RELATIONSHIP TO DECEDENT | BENEFICIARY'S DATE OF BIRTH |
|---|---|---|
| | | |

**NOTE:** If any designated beneficiary is deceased, submit that beneficiary's certified Death Certificate. If the beneficiary is the Deceased's estate, furnish certified letters of Administration or Letters of Testamentary, and Estate Tax ID Number. If the beneficiary is a minor, furnish certified Letters of Guardianship for the minor's estate and minor's social security number.

| WHEN DID ACCIDENT HAPPEN? (MONTH, DAY, YEAR) | TIME ☐ A.M. ☐ P.M. | WHERE DID ACCIDENT HAPPEN? (IF CITY OR TOWN, SHOW STREET NUMBER) |
|---|---|---|
| | | |

| WHAT WAS CAUSE OF DEATH? | DATE OF DEATH (MO., DAY, YEAR) ATTACH COPY OF DEATH CERTIFICATE. |
|---|---|
| | |

Does this apply with accidents?

HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY)

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED DECEASED FOR THE INJURIES CAUSING DEATH.

| NAME & ADDRESS | NAME & ADDRESS | NAME & ADDRESS |
|---|---|---|
| | | |

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED DECEASED DURING THE LAST FIVE YEARS (STATE AILMENTS INVOLVED).

| NAME | ADDRESS | AILMENT |
|---|---|---|
| | | |
| NAME | ADDRESS | AILMENT |
| | | |

LIST ALL WITNESSES TO ACCIDENT.

| NAME & ADDRESS | NAME & ADDRESS | NAME & ADDRESS |
|---|---|---|
| | | |

LIST OTHER COVERAGES AND AMOUNTS OF INSURANCE IN FORCE ON DECEASED'S LIFE.

| NAME OF COMPANY | POLICY NUMBER | EFFECTIVE DATE | AMOUNT OF INSURANCE |
|---|---|---|---|
| | | | |

HAVE DIVORCE PROCEEDINGS EVER BEEN INSTITUTED BY OR AGAINST THE DECEASED? IF YES, INDICATE WHEN, WHERE AND THE OUTCOME.

## AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating tomental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

**CALIFORNIA:** For your protection, California law requires the following to appear on this form: 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.

**For residents of New York**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each violation.

**For residents of Pennsylvania**: 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 and subjects such person to criminal and civil penalties.

**For claimants not residing in California, New York, or Pennsylvania**: 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.

| I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. | DATE SIGNED (MONTH, DAY, YEAR) | |
|---|---|---|
| SIGNATURE OF BENEFICIARY, AUTHORIZED REPRESENTATIVE, OR NEXT OF KIN | BUSINESS PHONE NUMBER | HOME PHONE NUMBER |
| X | ( ) | ( ) |

ADDRESS OF NEXT OF KIN (NO., STREET, CITY, STATE)