



**PROOF OF DEATH**

Provident Life and Accident Insurance Company  
Administrative Office, Voluntary Workplace Benefits Life Claims  
P.O. Box 9061, Portland, ME 04104-5046

**INSTRUCTIONS**

**IMPORTANT: Before completing this form, read the instructions, fraud statements, sign and date on reverse side. For Toll Free Assistance Call: 1-800-874-7481 Fax: 207-575-7133**

1. Beneficiary's Statement must be made by the person to whom the insurance is payable. If there is more than one beneficiary, all may join in one statement, or a separate Proof of Death form can be submitted for each beneficiary.
2. When the insurance is payable to a named beneficiary of legal age, the statement must be made by such beneficiary.
3. Include a copy of a certified death certificate.
4. If any named beneficiary predeceases the Insured, it will be necessary to submit a copy of a certified death certificate for each such beneficiary.
5. Please sign at bottom of back page.

**BENEFICIARY'S STATEMENT**

Deceased's Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Social Security Number \_\_\_\_\_ Sex  M  F  
 No./Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Policy No. \_\_\_\_\_ Amount of Insurance \$ \_\_\_\_\_  
 Date of Death \_\_\_/\_\_\_/\_\_\_ Place of Death \_\_\_\_\_  
 Cause of Death \_\_\_\_\_ Date deceased first consulted physician for last illness \_\_\_/\_\_\_/\_\_\_

Name and address of all physicians who attended Deceased during last illness and during three years prior:

NAME	ADDRESS	DATES OF ATTENDANCE	DISEASE OR CONDITION

If death due to injury, please explain accident in detail \_\_\_\_\_

Date of Injury \_\_\_/\_\_\_/\_\_\_

**REQUEST FOR TAXPAYER'S IDENTIFICATION NUMBER (IN LIEU OF FEDERAL FORM W-9)**

State your relationship to the Deceased \_\_\_\_\_

Your Social Security No.

or Employer Identification No.

**Certification** Under the penalties of perjury, I certify that this is my correct Taxpayer Identification Number, and that I am not subject to backup withholding. If you are subject to backup withholding, then place a check in the box.

Signature of Beneficiary \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

No./Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone No. ( ) \_\_\_\_\_ Age \_\_\_\_\_

# FRAUD WARNING STATEMENTS

## CLAIM FRAUD WARNING STATEMENTS

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio and Oklahoma, and others require the following statement to appear:

### Fraud Warning

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

### Fraud Warning for California Residents

For your protection, California law requires the following to appear:

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.

### Fraud Warning for Colorado Residents

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.

### Fraud Warning for District of Columbia, Maine and Virginia Residents

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

### Fraud Warning for Florida Residents

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

### Fraud Statement for New Jersey, New Mexico and 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 fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

### Fraud Statement for New York Residents

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing 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.

### Fraud Warning for Tennessee Residents

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

## AUTHORIZATION

I authorize any doctor, hospital, practitioner, pharmacist, clinic, other medical facility, or provider of health care, banking or financial institution, insurer or reinsurer, consumer reporting agency, governmental agency, including the Social Security Administration, Medical Information Bureau, Employers and other persons or institutions; to provide UnumProvident Corporation and its representatives data or records you may have regarding the employment, medical history and treatment (including records pertaining to psychiatric, drug or alcohol use history, and but not limited to, information regarding HIV status and test results) and income of the deceased.

I understand that any information pursuant to this authorization will be used to evaluate the claim and may be transferred to any agency, insurance support organization or person employed by UnumProvident Corporation, to assist with this purpose. This authorization is valid during the pendency of the claim. I understand I have the right to request a copy of this authorization and that a copy of this authorization will be sent to me if requested. A photostatic copy of this form will be as valid as the original.

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Beneficiary/Authorized Person's Signature

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Date Signed