BlueCross BlueShield of Illinois

Life Insurance Claim Form

Phone: (800) 367-6401 | Fax: (855) 645-8242

EMPLOYER INFORMATION FOR SUBMITTING A LIFE CLAIM

DearbornCares℠

Advance Payment of the Life Insurance Benefit

DearbornCares provides an advance payment of up to a total of $50,000 in 48 hours* to help cover their immediate expenses, such as funeral costs and medical bills.

- ▲ Pays up to a total of $50,000 of Employer-Paid Basic Life insurance benefits
- ▲ Applies to claims with 1, 2 or 3 named beneficiaries
- ▲ Available for covered employees and retirees

The Death Certificate is NOT REQUIRED for the advance payment.

Please complete Part 1 of the Life Insurance Claim Form in its entirety and include the Beneficiary Designation. Any remaining information in the checklist below must be submitted to us in order to complete the claim and receive the full payment.

*Pays up to a total of $50,000 to beneficiaries (maximum 3) of employer-paid basic life insurance benefits in 48 hours of confirmation of eligibility. The advance payment is either distributed to 1 beneficiary or divided up between 2 or 3 beneficiaries, as designated by the insured.

TPA Groups are not eligible for the DearbornCares program. This information is only a product highlight. DearbornCares has exclusions and limitations.

Employer Checklist for Submitting a Life Claim:

The employer/administrator must complete the claim form as indicated and send attachments mentioned below. We will advise you if further documentation is necessary to complete the claim process.

Please submit the following documentation:

- ☐ Life Claim Form
  Part 1 – Completed by the Employer/Administrator
  Part 2 – Completed by the Beneficiary(ies)
  Part 3 – Authorization for Release of Information to be completed by a beneficiary
- ☐ Enrollment Form, including any beneficiary changes (original, photocopy or screen print)
- ☐ Certified copy of the Official Death Certificate (for total coverages over $500,000, we require an original Certified Death Certificate with a seal)
- ☐ Payroll Records verifying the insured's annual earnings at the time of death (if the benefits are based on salary)
- ☐ If any portion of coverage is paid for by the insured, proof of payroll deduction.

For Accidental Death Benefits, provide the following:

- ☐ Official, completed police report
- ☐ Proof of seat belt/airbag use, if applicable
- ☐ Newspaper clipping(s) of accident, if applicable
- ☐ Coroner's report, findings and/or toxicology report

CLEAR FORM PRINT FORM

Return completed form to:
Blue Cross and Blue Shield of Illinois (BCBSIL)
Attn: Life Claims Department • P.O. Box 7070 • Downers Grove, IL 60515

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Part 1: To be completed by Employer/Administrator

Employer/Group Information			
Group Name:		Group Number:	
Subsidiary Name:		Account Number/Division:	
Group Address:	Street:		
	City:	State:	Zip:
Name and Title of Authorized Representative:			
Phone:		Email:	
Preferred Communication: ☐ Email ☐ Phone			

Employee Information			
Last Name:	First:		Middle:
Street:			Birth Date:
City:	State:	Zip:	Date of Death:
Phone:		Email:	
Employee SSN / ID:		Status: ☐ Active ☐ Retired ☐ Disabled ☐ Terminated	
Date of Hire:	Insurance Effective Date:	Last Day Worked:	Date Terminated:
Annual Salary:	Class:	Salary Effective Date:	
Employee's Date of Last Premium Contribution:		Hours Worked per Week:	

Deceased Information (If other than employee)			
☐ Spouse ☐ Dependent Child			
Last Name:		First:	Middle:
Birth date:	Date of Death:	SSN:	
Full-Time Student: ☐ Yes ☐ No		School:	
Was He/She Incapacitated and Reliant on the Employee for Financial Support: ☐ Yes ☐ No			

Be sure to include the Beneficiary Designation when submitting the Claim Form.

Insurance Information	
Basic Life: $	Supplemental/Voluntary Life: $
Basic AD&D: $	Supplemental/Voluntary AD&D: $

Is the death due to an accident? ☐ Yes (please complete the section below) ☐ No

Additional AD&D benefits being applied for: *(Please consult your certificate for additional benefits included with your coverage. All benefits may not apply)*

☐ Seat Belt	☐ Repatriation	☐ Coma	☐ Common Disaster	☐ Campus Violence
☐ Airbag	☐ Day Care	☐ In the Line of Duty	☐ Public Conveyance	☐ Other
☐ Education	☐ Spouse Training	☐ Felonious Assault	☐ Brain Damage	

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Signature of Authorized Employer/Plan Representative

Date

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Part 2: To be completed by Beneficiary

If there is more than one beneficiary, each must complete a separate form. See Important Information below if beneficiary is a minor.

Beneficiary Information			
Last Name:	First:		Middle:
Maiden Name:	Birth Date:	SSN / ID:	
Street:			
City:	State:	Zip:	Phone Number:
Email:	Relationship to Deceased:		

Deceased Information		
Last Name:	First:	Middle:
SSN / ID:	Group Number/Name:	

IRS Certification

Are you a U.S. Citizen: ☐ Yes ☐ No, IRS Form W-8 is required. Provide other work ID if available.

Under penalty of perjury, I certify that:

1. The number shown on this form is my correct Social Security/Taxpayer Identification number; and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person.

Certification Instructions

You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return.

The IRS does not require your consent to any provision of this document other than the certifications required to avoid back-up withholding. If you fail to certify, we may be required to withhold federal and state tax.

Be sure to include a certified copy of the Death Certificate for claims over $500,000.

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Signature of Beneficiary | Date

IMPORTANT INFORMATION

If the Beneficiary is:

a. A minor, an estate or incompetent to handle financial matters: provide an original court order appointing a legal representative or guardian to handle the financial affairs of the minor, the estate, or the incompetent.
b. Deceased: provide proof of death, a copy of the final certified death certificate, and documentation of the secondary beneficiary.
c. A trust: provide documentation verifying existence of the trust, documentation that the trust has been named the beneficiary, and the tax identification number of the trust.

Each beneficiary must complete and sign the Beneficiary/Claimant Statement

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Part 3: Authorization for Release of Information

(We will require a separate authorization for release of psychotherapy notes.)

I (the undersigned) authorize _____ physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; coroner's office; insurance or reinsurance company; government agency; department of labor; law enforcement or public safety department; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

Physician Name

Deceased Last Name:	First:	Middle:
SSN / ID:	Group Number/Name:	

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Signature of Beneficiary | Date

IMPORTANT INFORMATION

Claimant/Insured Information to be released:

- Data or records regarding medical history, treatment, prescriptions, consultations, autopsy (including medical reports, records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition(s));
- Any information regarding insurance coverage; and
- Accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).
- Information to be released to:
  Blue Cross and Blue Shield of Illinois
  P.O. Box 7070
  Downers Grove, IL 60515
- I understand that refusal to sign this Authorization may result in the denial of benefits.
- I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- I understand the information obtained by use of this Authorization will be used by BCBSIL (the Company) to evaluate my claim for death benefits. The Company will only release such information:
  - To its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
  - As may be required by law; or
  - As I further authorize.
- I understand that I may revoke this Authorization in writing at any time, except to the extent the Company has taken action in reliance on this Authorization. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signature below. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.
- A photocopy of this Authorization is to be considered as valid as the original.
- I understand I am entitled to receive a copy of this signed Authorization.

Signature (Claimant or Legal Representative) | Print Name | Date

If you are the legal representative of the Claimant, we may ask for additional documentation.

Street:		Phone Number:
City:	State:	Zip:

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