Grange Life Insurance Company
671 South High Street
Columbus, Ohio 43206
1-800-399-3797

Life Insurance Death Claim Form

Important: Please Read

For Universal Life, Whole Life and Annuity Policies

Tax Form Required

The Foreign Account Tax Compliance Act (FATCA) was enacted by Congress to target non-compliance by U.S. taxpayers using foreign accounts. Grange Life must verify the identity of the person receiving specific disbursements from universal life, whole life and annuity policies by requesting a W-8 or W-9 form.

Requests for the following transactions will require a W-8 or W-9 form:

- Partial Policy Withdrawals
- Policy Surrenders
- Death Claim Proceeds

What is a W-9 Form?

A W-9 form is an Internal Revenue Service form that is used by United States citizens to provide their social security number to persons or companies who are disbursing money to them. Grange Life requires a W-9 in order to verify the identity of individuals to whom it is making specific disbursements.

What is a W-8 Form?

A W-8 form is an Internal Revenue Service form that is used by non U.S. Citizens (individuals and entities) to establish their tax status in the United States. This form is to be used only if the requestor is not a citizen of the United States. There are four different types of W-8 forms, but the one used most commonly is the W-8BEN.

Where to Obtain a W-8/W-9 Form

Printable copies of the forms can be found at the IRS sites listed below:

W-8*: http://www.irs.gov/pub/irs-pdf/fw8ben.pdf
W-9: http://www.irs.gov/pub/irs-pdf/fw9.pdf

**this is for the most commonly used version called the W-8BEN*

Note: Grange Life Insurance Company is not a provider of the W-8 or W-9 forms.

What happens if a W-8/W-9 is not provided?

If a W-8 or W-9 is not provided, or if a submitted form is deemed to be inaccurate or incomplete, the FATCA regulations may require Grange Life Insurance Company to withhold 30% of the proceeds for federal tax purposes.

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This form is supplied by Grange Life without prior verification of coverage and without any assurances made by Grange Life to the recipient that they will be the appropriate payee or beneficiary of the death benefit proceeds.

INSTRUCTIONS:

- **Please complete all fields legibly in ink**
- **Please provide a certified death certificate (copies cannot be accepted)**
- **Minor Beneficiaries (Under 18 years) and Beneficiaries who are Mentally Incompetent** - when proceeds are payable to a minor child or to a mentally incompetent person, the Claim Form must be executed by a person named as Guardian. Please furnish the court appointed Guardianship Papers for the Estate of each minor child. Custody papers are not acceptable. If signing for an incompetent person, either Guardianship Papers or the Durable Power of Attorney papers must be furnished.
- **Estate as the Beneficiary** - when proceeds are payable to the Estate of an individual, this Claim Form must be executed by the court appointed Executor(s), Administrator(s), or Personal Representative. A copy of the court appointed and qualification must be furnished.

1. Decedent Information			
First Name	Middle Name	Last Name	
Street Address	City	State	Zip
Date of Birth / /	Date of Death / /	Cause of Death	
Policy Number(s)			

2. Physician(s) Information (only required if policy was placed in force or reinstated in the last two years)			
Physicians	Addresses	Dates of Attendance	Disease or Condition

Additional Life Insurance (only required if policy was placed in force or reinstated in the last two years)		
Name of Company	Amount of Coverage	Date of Policy
		/ /
		/ /

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3. Beneficiary or Claimant Information			
First Name	Middle Name	Last Name	
Street Address	City	State	Zip
Date of Birth / /	Daytime Telephone ( ) -	Relationship to Deceased	
Social Security or Tax ID Number	Citizenship *Are you a U.S. Citizen? Yes* ☐ *No* ☐ *If no, please specify country of residence* _____		
In What Capacity Or By What Title Do You Claim These Proceeds (check one) ☐ *Beneficiary* ☐ *Assignee* ☐ *Trustee* ☐ *Executor/Administrator* ☐ *Other (please explain)* _____			

4. Statement Of Lost Policy

Please return the original policy. If the policy is not available, complete the "Statement of Lost Policy section below.

I, _____, hereby certify that the policy number _____, issued or assumed by Grange Life Insurance Company, has been lost or destroyed. I have no knowledge of its whereabouts, and this policy has not been assigned, hypothecated, or pledged, except as indicated here _____
_____.

5. Payment Of Funds (choose one)

☐ **Single Lump Sum Payment**
Grange Life will send a check to each beneficiary for the full amount of their allotted percentage of the proceeds (as stipulated by the policy owner).

☐ **Proceeds Left at Interest**
The beneficiary leaves the proceeds with Grange Life and Grange Life will pay interest on the amount left with us until you decide to take the lump sum proceeds (see limitations below). Interest earned on the proceeds left with Grange Life may be taxable. An IRS Form 1099-INT will be mailed at the end of the year for interest earned.
The following limitations apply:

- This option is only available for specific policies and product types.
- Proceeds can be left in the account for a maximum of one year.
- The account is not FDIC insured.

Please consult with your tax and legal advisors regarding your personal circumstances.

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6. Signatures

We are required by law to give you the following notice:
Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

All Other States: 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.

Signature of Claimant	
Date of Signature	/ /
Relationship to Deceased	
Claimant's Street Address	
Claimant's City	
Claimant's State	
Claimant's Zip Code	

If signed on the behalf of another, give relationship(s) _____

Grange Life Insurance Company
671 South High Street, PO Box 1218
Columbus, Ohio 43216-1218

HIPAA Compliant Authorization for Release of Medical Information

_____ _____/_____/_____
Name of Deceased (please type or print) Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, including any facility run by the Veteran's Administration, or other health care provider, or any insurance support organization, governmental agency, group policyholder, employer, school, benefit plan administrator, banker, tax preparer, consumer reporting agency or the Social Security Administration that has provided payment, treatment or services to the deceased or on behalf of the deceased within the past 10 years ("Providers") to disclose the entire medical record, prescription history, medications prescribed and any other protected health information, employment information, financial information, school information and/or police record information concerning the deceased to Grange Life Insurance Company. 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. This information can also be released by insurers, reinsurers, the Medical Information Bureau (MIB), employers and consumer reporting agencies.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Grange Life Insurance Company may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage the deceased had or applied for with Grange Life Insurance Company.

This authorization shall remain in force for 30 months following the date of my signature below, and 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 providing written notification to the entity identified above, I understand that a revocation is not effective to the extent that any Provider has already relied on this Authorization to disclose information about the deceased or to the extent that Grange Life Insurance Company 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 is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Grange Life Insurance Company except as authorized by me or as required by law.

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release the complete medical records of the deceased, Grange Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Date: _____/_____/_____ (X) _____
Signature of Beneficiary / Claimant

(X) _____
Description of Personal Representative's Authority
or Relationship of Deceased