Guide to Making Your Life Insurance Claim (Deaths outside the U.S.)

We are sorry to learn about your recent loss and extend our condolences. As this is a difficult and stressful time for you, it is our objective to process your claim promptly and efficiently, minimizing any inconvenience for you. If you have any questions, please call us at 800.231.0801 (Press 4 in prompts) or send us a message at: https://www.americo.com/claims/#contact-claims. **Note that this form is not to be used if the death occurred in the United States or a territory of the United States.**

Section 1: Information

To submit a claim for life insurance, follow these steps:

1. Fill out the enclosed life insurance claim form completely, print, and sign (we must have an actual signature on the form). Provide all the information requested so we can process your claim as quickly as possible. Please initial any corrections you make on the form.
2. Send us the completed claim form, death certificate, original policy (if available), copy of obituary and documentation of any name changes for the beneficiary(ies).
3. Review the instructions below for the applicable beneficiary type before completing this form:

    - **Individual:** The statement must be completed by the individual beneficiary(ies).
    - **Trust**: The statement must be completed by the trustee(s) and include the full name of the trust along with the trust documents or certification of trust.
    - **Estate**: The statement must be completed by the Executor(s) or Administrator(s), and submitted with the Letters issued by the Court appointing that individual.
    - **Company or Corporation:** The statement must be signed by two officers and include each officer's title.
    - **Minor**: The statement may be completed by the Court appointed Guardian of the minor's Estate and submitted with a copy of the Court issued appointment or in accordance with other applicable state law.
    - **Assignee:** If the policy has been collaterally assigned by the owner prior to the death of the decedent, a statement of interest is also required. This document provides a statement of the assignee's interest and may be obtained by contacting our office.

Because death occurred outside of the United States or United States territory

A routine investigation will be conducted as part of our claim review. Please also be advised that for any payee(s) residing outside of the United States, any benefit payment will be sent by wire transfer to the payee of record.

We request that the payee(s) provide us with the following information (if not in the U.S.):

- **Bank Name/Address/Telephone Number**
- **Name on account (payee must provide documentation of ownership of the account)**
- **Account Number**
- **Swift Number**

For tips and frequently asked questions, please visit our website: https://www.americo.com/Content/ClaimsFAQ.pdf

Please mail your completed claim to the following address:

Regular Mail:
PO BOX 410288
Kansas City, MO, 64141-0288

Overnight Mail:
300 W. 11th Street
Kansas City, MO, 64105

If your claim is below $150,000.00 you may:

- Upload and send on our website (https://www.americo.com/claims/#contact-claims) **or** Email to forms@americo.com **or** Fax to: 800.395.9238

SECTION 1: About You (Beneficiary)

Please print your name the way you want it to appear on your payment. Each beneficiary should submit a separate claim form; however, we only require one death certificate.

Beneficiary Name (First, Middle, Last)		
Relationship to the Insured	Maiden Name (if applicable)	Social Security Number/TIN
Mailing Address		
City	State	ZIP Code
Country of Citizenship	Date of Birth (mm/dd/yyyy)	Gender
		☐ Male ☐ Female ☐ Other
Phone Number	Email address	

SECTION 2: About the Deceased

Deceased Name (First, Middle, Last)		
Residence Address		
City	State	ZIP Code
Date of Birth (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)	Gender
		☐ Male ☐ Female ☐ Other
Marital Status	Cause of Death	Manner of Death
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		

SECTION 3: About Your Claim

Please list the policy number and prefix (if applicable) for all policies on which you are making a claim.

SECTION 4: Tell us how you want to receive your claim payment

Check one:

☐ I would like my payment to be wire transferred. ONLY option for payment outside U.S.

☐ I would like to receive a check sent by USPS mail.

☐ I would like information on Alternative Settlement Options available. (We will send additional information on these options upon request).

- **For Illinois residents and policies issued in Illinois only: Unless payment is made within thirty-one (31) days from the date of receipt by the company of due proof of loss, interest shall accrue on the proceeds payable because of the death of the insured from date of death at a rate of 10% on the total amount payable or the face amount if payments are to be made in installments until the total payment or first installment is paid.**

If you are not in the U.S., a Form W-8BEN will be required. Go to https://www.irs.gov/pub/irs-pdf/fw8ben.pdf for form and directions.

SECTION 5: Certification and Signature (U.S. Citizens only)

By signing this claim form, you certify that:

- All the information you have provided is true and complete to the best of your knowledge.
- If we overpay you, we have the right to recover the amount we overpaid. This can happen if we find we've paid you more than you're entitled to under this life insurance claim, or if we paid you when we should have paid someone else. You agree to repay us the amount we overpaid. You also understand that if you do not repay us, we may take steps, including legal action, to recover the overpayment.
- You have read the Claim Fraud Warnings included with this form.
- If you selected the Financial Access Account, you have read the Financial Access Account Disclosures. This Claim Form represents a Supplemental Financial Access Account Agreement to which I agree to be bound.

Under the penalties of perjury, I certify:

1. That the number shown as my Social Security number in "Section 1: About you" above is my correct taxpayer identification number, and

2. That 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 has notified me that I am no longer subject to backup withholding, and

3. I am a U.S. citizen, resident alien, or other U.S. person*, and

4. I am not subject to FATCA reporting because I am a U.S. person* and the account is located within the United States.

(Please note: You must cross out Item 2 above if the IRS has notified you that you are currently subject to backup withholding because you failed to report all interest or dividend income on your tax return.)

*If you are not a U.S. Citizen, a U.S. resident alien or other U.S. person for tax purposes, please cross out items 3 and 4 above, and complete and submit form W-8BEN (individuals) or W-8BEN-E (entities).

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

Signature of Person/Representative Making Claim	Date signed (mm/dd/yyyy)

If acting as representative, please sign with title and provide supporting documentation.

SECTION 6: Claims Submission Checklist (please check off items you are sending with this form)

- ☐ Death certificate. **Note**: Because the death occurred outside the United States, we require an original certified death certificate. A certified death certificate has a raised or colored seal on it.
- ☐ Original policy. ☐ Check here if policy cannot be located.
- ☐ If you signed a document with a funeral home or assignment company that authorizes us to make a payment directly to them, a copy of that document. **Check box and enter total amount assigned here: $_____.**
- ☐ If the person died in an accident and you're making an accidental death benefit claim, proof of the accident - police reports and other supporting documents.
- ☐ If you have Power of Attorney, a copy of the appointment papers naming you as the attorney-in-fact for the beneficiary.

Fraud Notice Form

Before signing any claim form, please read the applicable fraud warning for the state where you reside and for the state where the insurance policy under which you are claiming benefit was issued. Many States require the Insurer to provide claimants with a Fraud Statement such as the following:

WARNING: 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.

The following States require the insurer to provide claimants with the specific language below:

Maine Tennessee, Washington, 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 may include imprisonment, fines or a denial of insurance benefits.

Delaware, Idaho, Indiana: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: 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 purposes 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.

Kentucky: 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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH R.S.A Section 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: 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 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.

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.

Pennsylvania: 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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years

Foreign Death Questionnaire

15-085-1

Policy Number:

Americo Financial Life and Annuity Insurance Company

DETAILS OF TRAVEL

1. Insured's Full Name *(please print)*			2. Phone Number *(in the United States)*
3. Home Address *(in the United States)*			
4. Employer Name *(list most recent employer)*	5. Employer Phone Number		6. Occupation *(please indicate duties if self-employed)*
7. Employer Address			
8. Date Insured left U.S. to Travel	9. Method of Travel	10. Intended Length of Trip	11. Date of Scheduled Return
12. Purpose of trip:			
13. Name and address of travel agency used for last travel arrangements:			
14. Name, address, and phone number of person(s) who traveled with the insured:			
15. Did the Insured travel by airplane? ☐ Yes ☐ No *If **Yes**, please attach a copy of the airline ticket or provide the name of the airline, flight date, time, and number:*			

DETAILS OF DEATH

16. Foreign Address at Time of Death			
17. Address where Death Occurred *(please include number, city, state, province, country)*			
18. Phone Number at Time of Death ☐ Land Line ☐ Cell Phone	19. Date and Time of Death	20. Cause of Death	

21. Names of Witnesses	22. Phone Numbers of Witnesses
	☐ Land Line ☐ Cell Phone
	☐ Land Line ☐ Cell Phone
	☐ Land Line ☐ Cell Phone

23. Name and Telephone Number of Person Who Notified You of Insured's Death *(Please provide full name)*
24. How were you notified of death?
25. Did police investigate Insured's death? ☐ Yes ☐ No *If **No**, please explain:*
26. Name of investigating officer, station name, address, and phone number:

Initials: _____

27. Name, address, and phone number of hospital(s) where Insured was treated:

28. Date of admission: _____

29. Name, address, and phone number of doctor or coroner certifying death:

30. Was an autopsy performed? ☐ Yes ☐ No

31. Insured's death was due to: ☐ Accident ☐ Illness ☐ Other: _____

32. Was the Insured ever treated in the U.S. for the illness causing death? ☐ Yes ☐ No
*If **Yes**, name and address of facility:*

33. Was the Insured hospitalized in the last five (5) years? ☐ Yes ☐ No
*If **Yes**, name, address, and phone number of facility:*

34. Name, address, and phone number of Insured's family physician:

35. Did the Insured have any type of health insurance coverage in the last five (5) years? ☐ Yes ☐ No
*If **Yes**, name and address of carrier, group number, and policy number:*

DETAILS OF REMAINS

36. Insured was: ☐ Buried ☐ Cremated	37. Date of Burial or Cremation	38. Phone Number of Facility that Provided Burial/Cremation ☐ Land Line ☐ Cell Phone

39. Were documents received to authorize the Insured's burial or cremation? *(If **Yes**, please provide a copy.)* ☐ Yes ☐ No

40. Name and address of facility that provided burial/cremation:

41. Was the funeral service recorded? *(If **Yes**, please provide a copy of the DVD.)* ☐ Yes ☐ No

42. Name, address, and phone number of funeral service involved in preparation of the body:

43. Name, address, phone number of person who performed the final service and type of facility (church, synagogue, mosque, etc.):

INSURANCE INFORMATION

44. Did the Insured have any other life insurance in force? ☐ Yes ☐ No
*If **Yes**, provide details below.*

Name of Insurance Company	Policy Number	Coverage Amount

45. Did the Insured ever receive Social Security or state welfare benefits? ☐ Yes ☐ No
*If **Yes**, begin date:* _____

Initials: _____

FAMILY INFORMATION

46. Name, address, and phone number of decedent's parents, if living:

47. Did the Insured have siblings? ☐ Yes ☐ No

*If **Yes**, provide details below:*

Sibling's Name	Sibling's Phone Number

48. Did the Insured have children? ☐ Yes ☐ No

*If **Yes**, provide details for each **adult** child below:*

Child's Name	Child's Address	Child's Phone Number

SUPPLEMENTAL INFORMATION

49. Was the Insured a U.S. citizen? *If **No**, please provide a copy of the Alien Registration Card.* ☐ Yes ☐ No

50. Was the Insured's death reported to the U.S. Embassy? *If **Yes**, please provide a copy of the Death of American Citizen Abroad form.* ☐ Yes ☐ No

51. Did the Insured have a U.S. driver's license? ☐ Yes ☐ No
*If **Yes**, state and license number (Please provide a copy.)* _____

52. Did the Insured have a passport? ☐ Yes ☐ No
If **Yes**, *country of issue (Please provide a copy of every page of the passport.)* _____
*In **No**, please explain:* _____

53. Did the Insured file income tax returns in the U.S. during the last two (2) years? ☐ Yes ☐ No
*If **No**, please explain:* _____

Please provide a copy of the Insured's Social Security card.	Please provide a recent photograph of the Insured.

Certification—I have read the information provide on the two (2) initialed pages and by my signature declare it is true and correct.

_____ _____ _____ _____

Signature Date Witness Date

Authorization and
Consent to Disclosure

21-057-1 (01/21)

This form is HIPAA compliant

Policy Number:_____

Decedent: _____

Purpose of Authorization: Process Insurance Claim

FOR HOME OFFICE USE ONLY

Name of Decedent: _____ DOB: _____ SSN: _____

Records Provider: _____ Type of records to be released: _____

Time period of requested records: _____ to _____

I/We, individually and/or as authorized representative for the decedent ("Decedent's Representative"), authorize any insurance or reinsurance company, employer, Social Security Administration, licensed medical physician, medical professional, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, clearing house, consumer reporting agency, and/or the Medical Information Bureau ("MIB, Inc.") or any other person, organization or institution that has any record of information about the decedent or minor children who are/were insured, to give Americo Financial Life and Annuity Insurance Company ("Americo"), its reinsurers or its authorized representatives, information about other insurance coverage, employment, age, general character, motor vehicle records, habits, court records, foreign travel, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including medications prescribed, chart notes, labs, x-rays and special tests, information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, and the use of drugs, alcohol, tobacco and psychotherapy notes and alcoholism, required by Americo to determine insurability and/or claims eligibility for the duration of the claim.

Americo may release information obtained by this Authorization to its reinsurers, to MIB, Inc., to other insurers with whom the decedent has/had policies or to whom the Decedent's Representative may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for the decedent, or as may otherwise be lawfully required. Although federal regulations require that Americo inform You (the Decedent's Representative) of the potential that information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Americo pursuant to this Authorization will be protected by federal and state privacy laws and regulations.

The Decedent's Representative may obtain a copy of this Authorization on request. This Authorization will be valid for two (2) years from the date signed. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. The Decedent's Representative understands that a copy of this Authorization will be provided, upon request, to the Decedent's Representative or a person authorized on the decedent's behalf.

This Authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this Authorization. Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

_____ _____

Signature of Next of kin or Executor (rix) of Estate | Date

_____ _____

Relationship | Initial here if Estate of Insured has not and will not be probated

_____ _____

Signature of Informant on Death Certificate | Date