



# Proof of Death

Group Life Insurance and  
Group Accidental Death Benefit Request  
(Filing instructions on reverse side)

Please fax or mail this claim to:  
The Business Council of New York State, Inc.  
Insurance Fund  
12 Corporate Woods Blvd.  
Albany, NY 12211  
FAX: (518) 432-7033

## A. Information About the Deceased

Deceased's Name (last, first, middle initial)		If deceased is known by any other name, provide Name (last, first, middle initial)			
Relationship to Employee	Social Security Number	Birthdate (MM/DD/YYYY)	Date of Death (MM/DD/YYYY)	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Last Residence: Street		City	State	Zip	

## B. Information About the Employee

Employee's Name (last, first, middle initial)		Social Security Number	Birthdate (MM/DD/YYYY)		
Last Residence: Street		City	State	Zip	
Date Employed (MM/DD/YYYY)	Employee's Work Location Name or Number	<input type="checkbox"/> Hourly <input type="checkbox"/> Salary	Date Last Worked (MM/DD/YYYY)		

Reason employee did not return to work after last day worked.

## C. Information About the Employee's Coverage

Employer's Name Business Council of NYS, Inc. Ins. Fund/		Representative's / Contact's Name / Email Address Marion Boyd			
Street Address 12 Corporate Woods Boulevard		City Albany	State NY	Zip 12211	
Telephone Number (518) 465-1571	Was an Accelerated Death Benefit, Accidental Dismemberment or Enhancement benefit such as Coma, Traumatic Brain Injury, Surgical Reattachment, Third Degree Burn, Children's Double Indemnity Benefit claim submitted prior to death? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Fax Number (518) 432-7033	Was waiver of premium claim submitted prior to death? <input type="checkbox"/> No <input type="checkbox"/> Yes				

Coverages for which benefits are in effect and being claimed

Group Coverage	Control	Suffix	Account	Plan	Effective date of employee's insurance (MM/DD/YYYY)	Amount of insurance in force as of the date last worked
<input type="checkbox"/> Term Life (TRM1)	888470				/ /	
<input type="checkbox"/>					/ /	
<input type="checkbox"/> Supplemental (TRM3)					/ /	
<input type="checkbox"/>					/ /	
<input type="checkbox"/> Dependent (TRM2)					/ /	
<input type="checkbox"/> [AD&PL (AD&D)] (ADD1)					/ /	
<input type="checkbox"/> Group Accident (GAC1)					/ /	
<input type="checkbox"/> Paid-up (PUP1)					/ /	
<input type="checkbox"/> Group Universal Life (GUL1)					/ /	
<input type="checkbox"/>					/ /	

If insurance is based on earnings, basic rate of earnings on date last worked or frozen salary  
\$ \_\_\_\_\_ per  Hour  Week, give number of hours worked per week \_\_\_\_\_  Month  Year

If insurance is based on other earnings, identify type (i.e., commission, bonus, etc.) and amount.  
Type \_\_\_\_\_ \$ \_\_\_\_\_

Date of Last Salary Increase (MM/DD/YYYY) \_\_\_\_\_

Has amount of insurance increased (other than salary) within the last two years?  
 No  Yes If Yes, give date (MM/DD/YYYY) \_\_\_\_\_

Was employee required to submit evidence of insurability to secure current coverage?  
 No  Yes

Identify last period covered by employee or employer contributions/premiums. \_\_\_\_\_

If insurance is not in effect, give date discontinued (MM/DD/YYYY) \_\_\_\_\_

Has the deceased converted his group insurance?  
 No  Yes If Yes, give Policy Number \_\_\_\_\_

Did the deceased have an Aetna long term care policy?  
 No  Yes If Yes, give Policy Number \_\_\_\_\_

**Deceased Information**

Name (last, first, middle initial)
Social Security Number

**D. Information About The Beneficiary(ies)**

	1.	2.	3.
Name	_____	_____	_____
Street	_____	_____	_____
City	_____	_____	_____
State/Zip	_____	_____	_____
Social Security Number	_____	_____	_____
Relationship to Employee	_____	_____	_____
Birthdate (MM/DD/YYYY)	_____	_____	_____
Telephone number	_____	_____	_____
Home	_____	_____	_____
Work	_____	_____	_____

Has benefit/ownership been assigned? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, to whom? (send copy of assignment)	Assignee's Social Security Number
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**E. Benefit Distribution Instructions**

Return the benefit payment directly to:

Beneficiary     Employer (Checkbook to Beneficiary Only)     Other The Business Council of NYS, Inc. Insurance Fund

**F. Employer's Instructions**

- Please submit this form, with the following attachments to the Life Insurance Service Center as soon as possible.
  - The insured's death certificate\*.
  - Original beneficiary designation and any or all change of beneficiary requests.
  - Enrollment forms (current and prior two years).
  - If beneficiary(ies) are minor children:
    - a) Their birth certificates & Social Security numbers\*
    - b) Letters of Guardianship\* or conservatorship of the estate of the minor child\*
  - If beneficiary is the insured's estate:
    - a) The Letters of Administration or Letters of Testamentary.\*
  - If beneficiary is a trust:
    - a) Provide copies of trust and letter of acceptance from trustee with Trust ID number.
  - If designated beneficiary predeceased the employee:
    - a) A copy of the beneficiary's death certificate
    - b) Aetna Affidavit of Sole Survivors completed by a family representative.
  - If Accidental Death benefits are being claimed, submit police/accident, autopsy and toxicology reports with any available newspaper articles concerning the accident, if the reports are available.\*
- Complete the deceased name on the top of Page 2 before the Life insurance claim is faxed to our office at 1-800-238-6239 or 1-800-AetnaFx. It is not necessary to follow-up with the original documents.
 

If you have any additional questions on the submission of this claim, please contact our office at 1-800-523-5065.

\* This information should be supplied by the beneficiary or the beneficiary's representative.

**G. Employer's Authorized Representative**

Any person who knowingly and with intent to injure, defraud or deceive 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.

**Attention California Residents:** For your protection, California law requires notice of 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.

**Attention 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.

**Attention Florida and Virginia Residents:** Any person who knowingly and with intent to defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Attention Kentucky, Ohio 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.

**Attention Louisiana Residents:** 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.

**Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Attention New York 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Name \_\_\_\_\_ Signature \_\_\_\_\_  
 Date (MM/DD/YYYY) \_\_\_\_\_ at (city, state, zip) \_\_\_\_\_