CUNA MUTUAL GROUP

CMFG Life Insurance Company

Administrative Office
PO Box 61 ▪ Waverly, IA 50677-0061
Phone: 800.779.5433

ACCIDENTAL DEATH CLAIM FORM

NOTE: A COPY OF THE POLICE REPORT MUST ACCOMPANY ALL CLAIMS RESULTING FROM A MOTOR VEHICLE ACCIDENT!

1. Policyholder's Name _____ Certificate Number _____
2. Name of Deceased _____ Date of Birth _____
3. Other Names the Insured/Deceased may have been known as _____
4. Home Address of Deceased _____
5. Deceased was: ☐ Policyholder ☐ Spouse ☐ Unmarried Dependent Child Sex: ☐ Male ☐ Female
   Soc. Sec. No. _____
6. Was this person covered by any other Accidental Death Insurance? ☐ Yes ☐ No
   a. Name of company(ies) and policy number for each _____
   _____
7. For what conditions has insured had medical attention in the last five years? _____
   _____
8. Date accident occurred that lead to death _____ Describe accident _____
   _____
9. Was insured hospitalized prior to death? (if so, please list dates) _____
10. Accident investigated by (law enforcement agency) _____
    Investigator name and phone number _____
11. To the best of your knowledge, did the use of alcohol, any drug, medicine, or sedative contribute to this person's death? ☐ Yes ☐ No If yes, please explain _____
    _____
12. For motor vehicle accidents, was the deceased driving? ☐ Yes ☐ No
    If a blood alcohol test was taken, list by whom _____ **Blood Alcohol Result** _____

If a premium is being paid for this coverage, please complete this section.

Name of deceased's spouse _____

List below all dependent children of the deceased under 18 years of age and unmarried children between 18 and 24 years of age who are full-time students and are dependent on the insured for at least 50 percent of their support. NOTE: If there are children that meet this criteria, please send the most recent copy of the insured's 1040 tax form showing child dependency OR send a copy of each dependent child's birth certificate.

Name of Child	Birth Date	School Attending	City & State	Grade Level

Were you a single parent at the time of loss? ☐ Yes ☐ No

FRAUD 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 may be guilty of a crime and subject to fines and confinement in prison, and denial of insurance benefits, depending on state law.

Name of Insured/Deceased _____ Date of Birth _____

Claim Authorization:

I authorize any health care providers, pharmacy benefit manager or other pharmaceutical firm, insurance companies, MIB, Inc., consumer reporting agency, the Department of Motor Vehicles, financial institution, or employer having information about the physical or mental condition, prescription drug records, financial status, employment status, or other relevant information about the Insured noted above to give all information (except psychiatric treatment notes) to CMFG Life Insurance Company ("Company") or its reinsurers to determine eligibility for benefits. Information obtained will be released only to reinsurers, MIB, Inc., persons performing business duties as delegated or contracted for by the Company related to my claim and subsequent insurance-related functions, as permitted or required by law, or as I further authorize. Some of the health information noted above may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with other applicable laws or regulations.

I agree this authorization is valid for the duration of the claim, a copy is as valid as the original, and I or my authorized representative can receive a copy upon request. I understand that: (1) I can revoke this authorization at any time by giving written request to the Company; (2) revocation of this authorization will not affect any prior action taken by the Company in reliance upon this authorization; and (3) failure to sign, or revocation of this authorization may impair the Company's ability to evaluate claims and may be a basis for denying this claim for benefits.

Signature of Beneficiary	Printed Name of Beneficiary	Relationship to Insured
Mailing Address	Beneficiary's Date of Birth	Date
City / State / Zip Code		( ) – Telephone Number

Beneficiary Certification of Taxpayer Identification No. **(Must be completed to process.)**

Beneficiary Social Security No. ☐☐☐ – ☐☐ – ☐☐☐☐ **OR** **Trust or Estate Taxpayer ID No.** ☐☐ – ☐☐☐☐☐☐☐

Under penalties of perjury, I certify that:

1. I am a U.S. person (including a U.S. resident alien) **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 has notified me that I am no longer subject to backup withholding, **and**
3. The number shown on this form is my correct taxpayer identification number (TIN).

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 you have failed to report all interest and dividends on your tax return. For payments other than interest, you generally are not required to sign the Certification, but you must provide your correct TIN.

Settlement Options

Lump Sum:

☐ EFT (Electronic Funds Transfer) Complete EFT Section
Please toss or recycle the following page if EFT option is not chosen

☐ By Check

Interest Option*:

☐ Interest option (interest paid or accumulated)

*To request a quote of the current interest rate, please contact our office.

Your election is final once a lump sum payment is made or settlement option agreement is issued.

EFT (Electronic Funds Transfer) SECTION

For your convenience, we will retain your personal account information provided to automatically credit your account approximately two business days after the payout date. **Please complete the financial institution information below.**

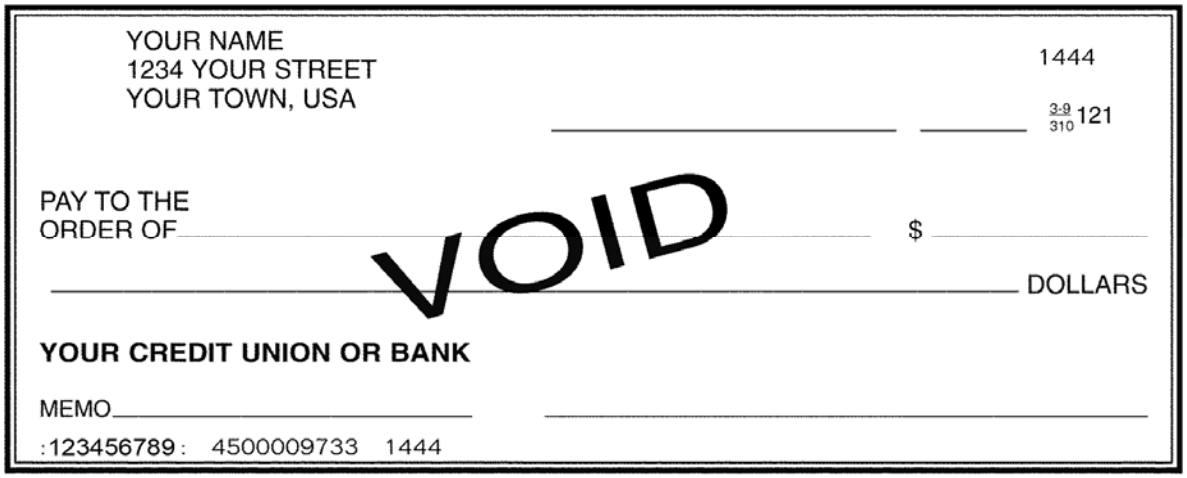
Name of Financial Institution _____ Phone Number _____ City/State _____

Account Owner _____ Account Number _____

Routing/Transit Number (nine digit number) _____

☐ Checking/Share Draft

Please attach a void check so we may obtain the correct account numbers. Your name must be pre-printed on the void check and deposit tickets for a savings account are not permitted.



If a void check is not received with this form, the proceeds will be sent by check.

Electronic Funds Transfer means the funds will be in your Financial Institution within 48 hours from the date the transaction is processed. If your Financial Institution is closed on that day, the money will be in your account the first working day following.

I understand this form is supplied for the convenience of persons providing information to the Company. In furnishing this form, the Company does not waive any rights nor admit liability. Coverage shall be governed solely by the terms of the policy.

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

_____ _____

Signature of Beneficiary Date

☐ Check if you are NOT a U.S. Citizen

ACCIDENTAL DEATH PHYSICIAN'S STATEMENT

This is to be completed by the Attending Physician.

1. Name of Deceased _____ Date of Birth _____

2. Address at Time of Death _____
   Number and Street City State ZIP Code

3. Date of Death _____ Place (if in hospital, give name) _____

4. Was insured hospitalized prior to death? Provide dates: from _____ to _____

5. Was death due to: ☐ Suicide ☐ Homicide ☐ Illness ☐ Accidental Bodily Injury ☐ Undetermined

6. Immediate Cause of Death (if injury, give details and dates) _____

   _____

   Secondary or Contributory Cause of Death _____

   _____

7. Was the injury described above directly and independent of all other causes sufficient to produce death?
   ☐ Yes ☐ No

8. To what extent did any disease or impairment contribute to the death? Give the dates and duration of each as closely as you can:

   _____

   _____

   Name Disease or Impairment _____

   _____

9. To the best of your knowledge, did the use of alcohol, any drug, medicine, or sedative contribute to this person's death?

   ☐ Yes ☐ No If yes, please explain _____

   _____

10. Was there an autopsy, inquest or post mortem examination? ☐ Yes ☐ No If yes, by whom? (Provide name and address)

    _____

    _____

11. **For Motor Vehicle Accidents ONLY:**

    Was a blood alcohol test taken? ☐ Yes ☐ No Results _____ **(ATTACH A COPY OF REPORT)**

    If so, name of facility _____

12. Form completed by: ☐ Coroner ☐ Medical Examiner ☐ Attending Physician ☐ Family Physician

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

Physician Name (Print) _____

Physician's Signature _____ _____ _____
Date Telephone Number

Address _____
Number and Street City State ZIP Code