



## The Baltimore Life Insurance Company

Corporate Office: 10075 Red Run Blvd. | Owings Mills, MD 21117-4871  
(410) 581-6600 | (800) 628-5433 | [baltlife.com](http://baltlife.com)

Dear Claimant,

The Baltimore Life Insurance Company would like to express our sympathy to you for the loss of your loved one. We understand that this is a difficult time and can assure you of a timely response to questions you may have about the claims process. Before completing the enclosed form, please carefully review the Frequently Asked Questions to determine what documents are required, and additional information for special situations.

We are here to help you. If you need assistance in completing the Claim Form or have any other questions, your Baltimore Life representative is ready to assist you. Please call toll-free 1-800-628-5433.

Additionally, your local Baltimore Life agent can help you with other insurance needs.

---

## Frequently Asked Questions

*When Filing a Death Claim...*

### Submitting Your Claim

#### Can I submit claim paperwork by fax or email?

- **\$20,000 and over:** An original, certified death certificate with raised or colored seal **must be mailed via U.S. postal** to the corporate address as shown above.
- **\$10,000 – \$19,999:** A **legible copy** of the death certificate **plus another proof of death** (e.g., obituary, funeral home bill or contract) can be faxed to (866) 879-9867 or emailed to [claimsfax@baltlife.com](mailto:claimsfax@baltlife.com).
- **\$9,999 or less:** A **legible copy** of the death certificate can be faxed or emailed.

The claim amount is based on the total claim amount across all policies. For example, a \$20,000 total claim amount for all Baltimore Life policies. In all instances, a certified death certificate must include the manner/cause of death and accompany this Claimant's Statement with any other pertinent forms, where applicable.

### Processing Time

#### Once I submit my claim, how long will it take to be processed?

- For non-contestable claims, the standard turnaround time for claim processing is **7-10 business days from receipt of all required paperwork.**

### Beneficiary Is Deceased

#### What if the beneficiary(s) to this policy predeceased the insured?

- You will need to also submit proof of death of the beneficiary(s) in the form of an obituary, mass card, or copy of the death certificate.
- The death claim proceeds become payable to the contingent beneficiary(s).

#### What if the beneficiary(s) died after the insured?

- You will need to submit proof of death of the beneficiary(s) in form of an obituary, mass card, or copy of the death certificate.
- The death claim proceeds become payable to the beneficiary's estate.
- The appointed representative of the estate must complete the Claimant's Statement and send a copy of the *Letters of Testamentary/Administration*.

### Claims Payable to the Estate

#### What will I need to submit if the claim is payable to the estate?

- The appointed representative of the estate must complete the Claimant's Statement and send a copy of the *Short Certificate/Letters of Administration*.
- The document must show that you are Executor of the estate and the EIN (estate identification number).

## **More Than One Beneficiary**

**If there is more than one beneficiary to the policy, will all beneficiaries need to submit a separate death certificate and claimant's statement?**

- No, only one death certificate is needed.
- Yes, all beneficiaries must complete a Claimant's Statement.

## **Payment to the Funeral Home**

**What will be needed to submit payment from the policy to the funeral home?**

- To pay the proceeds to the funeral home, Baltimore Life will need the funeral home's *Assignment* submitted with the claim paperwork and signed by the beneficiary(s).
- A copy of the itemized funeral bill is need for irrevocable funeral home assignment.

## **Contestable Claim**

**What is a contestable claim?**

- A contestable claim is a claim where the insured has died within two years of the policy issue date or reinstatement date.

**What documents will I need to submit if my claim is contestable?**

- Form 7712 *Claims Authorization for Health-Related Info (HIPAA)*, which authorizes us to obtain doctor(s) and/or hospital information. However, a medical facility may request additional paperwork from you to be completed to release information.
- If applicable, a Next-of-Kin Affidavit or Letters of Testamentary/Administration if a personal representative has been appointed.

## **Beneficiary Is Medically Incapable of Filing Claimant Statement**

**What happens if the beneficiary is unable to file a claim due to mental or physical illness?**

- The funds will be paid to the beneficiary on file.
- The beneficiary's Power of Attorney (POA) can sign the claim paperwork on behalf of the beneficiary. The POA documentation must be submitted along with the claim paperwork.

## **Death Outside of the United States**

**What will I need to submit if the insured died outside of the United States?**

- You will need to submit the official record of death authenticated by a Diplomatic and Consular Representative of the U.S. along with a Claimant's Statement, and any other pertinent forms, if applicable.

# Claimant's Statement

The death certificate must include the manner/cause of death. Please do not mail the original paperwork via U.S. postal mail if it is faxed or emailed.

- **\$20,000 and over:** An original, certified death certificate with raised or colored seal must be mailed via U.S. postal to the address shown above.
- **\$10,000 – \$19,999:** A legible copy of the death certificate **plus another proof of death** (e.g., obituary, funeral home bill or contract) can be faxed to (866) 879-9867 or emailed to [claimsfax@baltlife.com](mailto:claimsfax@baltlife.com).
- **\$9,999 or less:** A legible copy of the death certificate can be faxed or emailed.

The claim amount is based on the total claim amount across all policies. For example, a \$20,000 total claim amount for all Baltimore Life policies.

## Policy Number(s):

--	--	--	--

## Section A: Deceased Information

Name of Deceased	
Also Known As (AKA) (Other Complete Names to Check)	
Date of Birth	Date of Death

## Section B: Beneficiary Information

If proceeds are payable to an estate, the appointed representative's information must be completed below along with the EIN (estate identification number).

Name of Beneficiary (or Appointed Representative Information)		Relationship to the Deceased
Complete Mailing Address of Beneficiary (or Appointed Representative's Address) Street (PO Box is not an acceptable formal address)		
City	State	ZIP Code
Social Security Number of Beneficiary (or EIN)	Date of Birth	
Email Address <i>(This information will be used for communication purposes between the Beneficiary and The Baltimore Life Companies.)</i>		Daytime Telephone

**Section C: Withholding Election of Claimant**

*All policies may not apply to the provisions in this section.*

I have read the Notice of Federal Income Tax Withholding and understand that if I elect not to have Federal income tax withheld, I am responsible for payments of Federal income tax on the taxable portion of this distribution. I may also be subject to tax penalties under the estimated tax payment rules if my payments of estimated tax and withholding, if any, are not adequate.

**I DO** /  **I DO NOT** want Federal income tax withheld from my claim distribution. (**10%** will be withheld unless another amount is elected here \_\_\_\_\_%) State income taxes should be withheld if required by my state of residence.

Under penalties of perjury, I certify that: 1) the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); 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) I am a U.S. citizen or other U.S. person (including a U.S. Resident ); and 4) I am exempt from the Foreign Account Tax Compliance Act (FATCA) reporting.

Check this box if the IRS has notified you that you are subject to backup withholding.

The Internal Revenue Service does not require your consent to any provisions to this document other than the certification to avoid backup withholding. If we are required to report this transaction to the IRS, we will notify you and the IRS next January.

I certify the information provided is true and complete to the best of my knowledge. I acknowledge that I have read the State Required Fraud Warnings on the following pages of this form.

**x** \_\_\_\_\_  
Signature of Claimant Date

\_\_\_\_\_  
PRINTED NAME

**Section D: Contestable or Reinstated Policy**

**Please do not complete Form 7712 or this Section D if you are submitting a claim on an annuity policy. Only complete this section if the policy has been issued or reinstated within two (2) years PRIOR to the date of death.**

Please list the name(s) of the insured’s personal physician, doctors, hospitals, or institutions that the insured had seen **within two (2) years prior to the date of death**. Must also complete and include Form 7712 Authorization of Release of Health-Related Information.

Name	Name
Address	Address
Name	Name
Address	Address

*If Section D above was not completed, please skip to Section E and do not complete Form 7712 HIPAA on the next page.*

**Authorization for Release of Health-Related Information**  
**This authorization complies with the HIPAA Privacy Rule**

\_\_\_\_\_  
Printed Name of Insured

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth

*This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by law.*

**Covered entities:** Failure to sign this Authorization, or subsequent revocation of this Authorization, may impair the ability of The Baltimore Life Insurance Company to process your application or evaluate claims, and may be a basis for denying an application or claim for benefits; however, your ability to receive health care services will not be changed if you do not sign this Authorization.

**Non-covered entities:** Your failure to execute this authorization may result in the Baltimore Life Insurance Company being unable to collect information relating to you and result in denial of your application for life insurance.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy benefit manager, pharmacy, medical facility, or other health care provider that has provided payment treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to The Baltimore Life Insurance Company and its agents, employees, and representatives. 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.

By my signature below, I acknowledge that any agreements I have made to restrict my 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 my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Baltimore Life Insurance Company may:

- 1) Underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations;
- 2) Obtain reinsurance;
- 3) Administer claims and determine or fulfill responsibility for coverage and provision of benefits;
- 4) Administer coverage; and
- 5) Conduct other legally permissible activities that relate to any coverage I have or have applied for with The 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 sending a written request for revocation to:

**The Baltimore Life Insurance Company**  
**10075 Red Run Boulevard**  
**Owings Mills, MD 21117-4871**  
**Attention: Privacy Official**

I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Baltimore Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself; any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information; My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization; and further, if I refuse to sign this authorization to release my complete medical record, The Baltimore 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 acknowledge that I have received a copy of this authorization.

\_\_\_\_\_  
Signature of Claimant / Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Claimant / Representative

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name of Witness

**Section E: Optional – May Request for Electronic Deposit of Insurance Proceeds**

I authorize the Baltimore Life Insurance Company to electronically deposit funds from the above policy contract into the bank account described below. If the Company makes an error and deposit funds to any account that it should not have been deposited, I authorize the Company to retrieve the monies erroneously deposited to my account.

**Baltimore Life can only deposit money into an account with your name.**

**Must Deposit to a Checking Account (Savings Account is not honored under this request).**

If you choose to receive proceeds by direct deposit instead of check, please complete the required information:

Bank Name <i>(Required)</i>	
Bank Routing Number <i>(Required)</i> <small>Must Be Nine 9 Digits</small>	Account No.

**x** \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Claimant

*Please provide a copy of a voided check or proof of your bank account to process a direct deposit.*

**ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF COMMITTING A FRAUDULENT ACT WHICH IS A CRIME AND SUBJECT TO CRIMINAL PROSECUTION.**

**State Required Fraud Warnings**

**ALABAMA:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**ALASKA:** A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**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.

**ARKANSAS, LOUISIANA, WEST VIRGINIA:** 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.

**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 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.

**Delaware, IDAHO, INDIANA:** 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.

**District of Columbia: Warning:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**FLORIDA:** Any person who knowingly and with intent to injure, 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.

**KANSAS:** 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 insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

**KENTUCKY:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

**MAINE, TENNESSEE, VIRGINIA, WASHINGTON:** 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 and denial of insurance benefits.

**MARYLAND: WARNING:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**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 RSA 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 Mexico:** 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 civil fines and criminal penalties.

**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.

**OKLAHOMA WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**OREGON:** Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

**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.

**RHODE ISLAND:** 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.

**TEXAS:** 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.