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SYMETRA FINANCIAL

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135

GROUP LIFE INSURANCE DEPENDENT'S DEATH OR DISMEMBERMENT CLAIM

Mailing Address:
Symetra Life Insurance Company
PO Box 2993
Hartford, CT 06104-2993
Phone 1-800-943-2107
Fax (860) 392-3672
TTY/TDD 1-800-833-6388

POLICYHOLDER-EMPLOYER INSTRUCTIONS: See attached notice
Please complete this side of the form.
Ask the Employee to complete the reverse side of the form (Claimant's Statement).
Submit with the following documents:
- Certified copy of deceased's death certificate
- Copy of the Employee's enrollment form

For an accidental death or dismemberment claim provide a police report, newspaper article or similar document that describes the accident or dismemberment.

Group Policy No. _____ ERISA Group Plan ☐ Yes ☐ No

Amount(s) claimed: ☐ Basic Life $ _____ ☐ Basic Accidental Death & Dismemberment (AD&D) $_____

☐ Supplemental Life $ _____ ☐ Supplemental AD&D $ _____

DEPENDENT INFORMATION

1. Name of deceased dependent _____ Dependent SSN _____
2. Relationship to employee _____
3. Effective date of dependent coverage _____ Date of death _____

EMPLOYEE INFORMATION

4. Name of employee _____ Employee SSN _____
5. Employee address _____
6. Hours worked per week _____ ☐ Full-time ☐ Part-time ☐ Current salary $ _____ per ☐ hour ☐ month ☐ week ☐ year
7. Date employed _____ Effective date of employee coverage _____
8. Occupation _____ Department _____
9. Was employee employed and insured at time of dependent's death? ☐ Yes ☐ No Last date premium paid for employee _____
10. If employee no longer employed, date employment terminated _____
11. Do you recommend payment of this claim? _____ Remarks _____

- I certify that the above employee met the eligibility requirements of the policy and was insured under the policy at the time of death of the dependent.
- I am not a beneficiary nor am I related to the dependent or to a beneficiary.
- I am an authorized employer representative and confirm that the above statements are true.
- I have read the attached fraud notice.

Name of Policyholder-Employer _____

Address _____

Phone _____ Fax _____ E-mail Address _____

Signature _____ Print Name _____

Title _____ Date _____

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CLAIMANT'S STATEMENT

INFORMATION ABOUT YOU:

1. Your name (please print or type) _____

2. Social Security number _____

   ☐ Check this box if you have been notified by the Internal Revenue Service that you are subject to backup withholding on interest and dividends, under provisions of 3406(a)(1)(c) of the Internal Revenue Code.

3. Your date of birth _____ ☐ Male ☐ Female

4. Your phone number (in case we need to contact you): Day _____ Evening _____

5. Your address _____
   Street Address

   _____
   City State Zip

6. Last address of deceased dependent _____

7. If deceased dependent is your spouse, date of marriage _____

8. If deceased is a dependent child, answer the following questions:
   - Was the dependent child attending school? ☐ Yes ☐ No If yes, describe school and whether full or part-time student.

     _____
   - Was the dependent child working full-time? ☐ Yes ☐ No

9. If dependent was confined in a hospital since the effective date of dependent coverage, please name the hospital and date of confinement:

   _____

As a service to you if the proceeds payable total $10,000 or more, you may elect to deposit the proceeds into an interest-bearing draft account (Secured Benefits Account®). Please make your selection under item 10 below and read the Secured Benefits Account section on the following page for important information.

10. Please indicate how you want benefits to be paid: ☐ Secured Benefits Account
    ☐ Lump-sum check

YOUR SIGNATURE:

I certify, under penalty of perjury, that the information I have provided in this Claimant's Statement is true, correct, and complete to the best of my knowledge. I have read the fraud notices and Secured Benefits Account information included with this Statement.

_____ _____
Your Signature Date

SECURED BENEFITS ACCOUNT®

If you have elected a Secured Benefits Account, an interest-bearing draft account will be established for each beneficiary eligible for at least $10,000. Here are some important facts about the Secured Benefits Account (Account):

SAFE	The full amount in the Account, including all interest earned, is completely guaranteed by Symetra. The Account is not insured by the Federal Deposit Insurance Corporation or any federal agency, but is guaranteed by the State Guaranty Associations. The beneficiary may wish to contact the National Organization of Life and Health Insurance Guaranty Associations (www.nolhga.com) to learn more about the coverage limitation to his or her account.
COMPETITIVE	The Account earns interest at money market rates that are responsive to current market conditions. Interest is compounded daily and credited monthly on the Account's balance, increasing the annual yield. The beneficiary may want to consult with a tax advisor as there may be tax on the interest earned.
CONVENIENT	The Account provides easy immediate access through a personalized draft book for the beneficiary as soon as the claim is approved and processed. The beneficiary will receive monthly statements via postal mail, which show the Account's balance and the interest earned on the Account.
FREE	The beneficiary pays nothing for this Account. There are no monthly service charges or charges for checks.
FLEXIBLE	Drafts can be written from $250 up to the full amount of the proceeds at any time just by writing a draft. There are no limits on the number of drafts that can be written each month. The beneficiary may withdraw all or part of the money in the Account at any time with no penalty or lost interest. If the Account falls below $500, the balance is automatically paid to the beneficiary and the Account is closed.
ADDITIONAL INFORMATION	If you need more information or have questions, please call us toll free at 1-800-796-3872 ext. 21012.

FOR FURTHER INFORMATION, PLEASE CONTACT YOUR STATE DEPARTMENT OF INSURANCE.

Please read the following notice that we are required by law to give to you.

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

CALIFORNIA:
For your protection California law requires the following to appear: 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.

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.

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.

LOUISIANA:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information for payment of a loss is guilty of a crime and may be subject to fines and confinement in prison.

MAINE, TENNESSEE, 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 or a denial of insurance benefits.

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

NEW JERSEY:
Any person who includes any false or misleading information on an application for an insurance policy 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.

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

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, 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.

VIRGINIA:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated the state law.