



Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141
Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
cinfin.com ■ 513-870-2000

Claimant's Statement for Life Insurance Benefits

Please accept our sincere sympathy for your loss. We hope to make the claim process as simple as possible by providing the checklist of required items shown below. Additional items may be requested from Life Claims if necessary.

We are here to help with any questions. You may contact us at 888-212-6970, option 1, Mon-Fri 8 a.m. to 4:30 p.m. EST, or by email at life-healthclaims@cinfin.com.

- Death Certificate:** A certified death certificate, including cause and manner of death, must be provided to us. If there are multiple beneficiaries, we only need one death certificate.
- Policy:** Please destroy the original policy if it can be located. No future claims can be filed for the policy included on this claim form.
- Claimant's Statement:** Please be sure to follow the instructions carefully and complete all applicable sections. If there is more than one claimant, each person must complete a separate Claimant's Statement.
 - Section A:** List all policies for which you are claiming a benefit. Provide the insured's information.
 - Section B:** Complete Section B1 or B2, depending on the type of beneficiary.
 - Section C:** Choose the Payment Option you prefer.
 - Section D:** Review the Substitute W-9 information.
 - Section E:** Be sure to sign the claim form prior to submitting to the company.
- Authorization to Release Medical Information:** Complete this if the insured died within two years of the dates the policy was issued or reinstated.

Please return forms using the most convenient method shown below.

Regular mail: The Cincinnati Life Insurance Co Life Claims P.O. Box 145496 Cincinnati, OH 45250	Overnight mail: The Cincinnati Life Insurance Co Life Claims 6200 S. Gilmore Rd Fairfield, OH 45014
Email: life-healthclaims@cinfin.com	Fax: 513-870-2969

Forms included:

Claimant's Statement Form CLI-8695 (7/25)
Authorization for Release of Information Form CLI-8513 (9/21)
State-Required Notifications Form CLI-6323 (1/14)
Claim Fraud Warning Statements Form CLI-8854

CLAIMANT'S STATEMENT

Instructions:

- ▶ Complete all applicable sections. If information is incomplete or missing, the claim will be delayed.
- ▶ Each beneficiary must submit a separate form. We only need one death certificate.

Section A. Policy Information - Insured's Information

Policy numbers under which claim is being made:

Insured's Name in Full: _____
First Middle Last

Also Known As: _____
(Nicknames, maiden name, etc)

Home Address at Time of Death: _____

City, State, ZIP: _____

Social Security Number: _____

Date of Birth: _____ Place of Birth: _____

Date of Death: _____ State of Residence at Death: _____

If policy was issued or reinstated within 24 months, please provide the name and address of all physicians who attended deceased during the past five years:

Full Name	Street Address, City, State, Zip	Date of Visit	Disease or Condition

Use additional sheets if necessary.

Section B. Claimant/Beneficiary Information

Instructions:

- ▶ Is the beneficiary an individual? Yes No If Yes, complete Section B1
- ▶ Is the beneficiary a minor? Yes No If Yes, the guardian of the minor's estate must complete Section B1
- ▶ Is the beneficiary an estate? Yes No If Yes, the executor/administrator must complete Section B2
- ▶ Is the beneficiary a trust? Yes No If Yes, the trustee(s) must complete Section B2

Section B1: Complete fully if Beneficiary is an Individual or Minor

Claimant/Beneficiary: _____

Also Known As: _____

SSN: _____ Date of Birth: _____

Relationship to Insured: _____

Mailing Address: _____
Street City State ZIP

Email: _____

Best Contact Number: _____ Cell Home Work

Best Time to Call: _____ AM PM

For Minor Beneficiaries, submit copies of the Letters of Guardianship of the Minor's estate.

Section B2: Complete fully if Beneficiary is a Trust or Estate

Name of Trust or Estate: _____

Trustee or Executor Name: _____

Date of Trust: _____ TIN/EIN: _____

Mailing Address: _____
Street City State ZIP

Email: _____

Best Contact Number: _____ Cell Home Work

Best Time to Call: _____ AM PM

For Trust Beneficiaries, a trustee certification form and an EIN Confirmation or Verification letter from the IRS are needed.

For Estate Beneficiaries, a copy of the Letters Testamentary appointing the Executor or Administrator and an EIN Confirmation or Verification Letter from the IRS are needed.

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Section C. Payment Options for Life Insurance Benefits

You are eligible to select from the following payment options, unless the policy restricts your rights. ***Please indicate which option you prefer.***

- Lump Sum Payment via Electronic Fund Transfer (EFT):** Send a copy of a voided check or bank account statement. Be sure that it includes the accountholder's name, bank routing number, and account number.
- Lump Sum Payment via Check:** If proceeds are payable to a minor, corporation, estate or trust, payment will be made via check.
- Settlement Option:** Please refer to the policy to determine which settlement options are available to you. If you have questions regarding settlement options, you may contact Life Claims at 888-212-6970.

Section D. Substitute W-9 Certification

CERTIFICATION – Under penalty of perjury, I certify that:

1. The number shown on this form is my correct Taxpayer Identification Number, 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. person or U.S. resident alien, and
4. I am exempt from Foreign Account Tax Compliance Act (FATCA) reporting.
 - Check this box if you are not a U.S. citizen or U.S. resident for tax purposes. Complete form W-8BEN.
 - Check this box if you have been notified by the IRS that you are subject to backup withholding because you have underreported interest or dividends on your tax return.

Section E. Signature

I do hereby make claim to the policy(ies) listed in Section A of the Claimant's Statement. I declare that the answers recorded are true and complete to the best of my knowledge. I have read the applicable fraud statement. I agree that the furnishing of this and any supplemental forms do not constitute an admission by the Company that there was any insurance in force on the life in question, nor a waiver of its rights or defenses.

Signature of Beneficiary, Executor, or Trustee(s)

Date



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Authorization for Release of Information

Insured's Name: _____ Insured's Date of Birth: _____
Please Print

I, the Insured named above or the Personal Representative acting on behalf of the insured, hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical or medically-related facility; the Veterans Administration; Social Security Administration; Internal Revenue Service; financial institution; employer; consumer reporting agency; law enforcement agency or governmental entity; prescription database service; MIB or any organization that has any medical or nonmedical information regarding the Insured to give all such information to The Cincinnati Life Insurance Company or its authorized representative.

This shall include but not be limited to any information regarding the Insured's health history, including all consultations and treatments about mental illness and the use of drugs, alcohol or tobacco (excluding psychotherapy notes); prescription drug information; Human Immunodeficiency Virus (HIV) infection; Acquired Immune Deficiency Syndrome (AIDS); and the diagnosis, treatment or prognosis of any physical condition.

The patient or the patient's representative must read and sign the following statements:

1. I understand that this information will be used to evaluate my claim for insurance benefits and if I refuse to sign this authorization to release my records, The Cincinnati Life Insurance Company may not be able to investigate and/or pay my claim.
2. Information disclosed pursuant to this authorization may not be subject to state or federal privacy regulations and laws.
3. I may revoke this authorization at any time by sending a written request to The Cincinnati Life Insurance Company at the above address, but such revocation will not affect information that has already been requested, collected, used or disclosed in reliance on this authorization.
4. This authorization will be valid from the date signed for a period of two years unless revoked in writing.
5. Any request that I have made to my medical providers to restrict information disclosed does not apply to this authorization.
6. I may obtain a copy of this authorization form by sending a written request to The Cincinnati Life Insurance Company at the above address.
7. A photographic copy of this authorization shall be as valid as the original.

Signed on: _____
Month Day Year

Policy number(s) _____

Print Name of Insured or Personal Representative

Signature of Insured or Personal Representative

Relationship to Insured
(indicate if Personal Representative)



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STATE-REQUIRED NOTIFICATIONS

For policies issued in Illinois*:

The state of Illinois requires that we notify you that we will pay 10% interest if we have not processed the claim within 31 days of receipt of claim requirements.

For policies issued in California*:

The state of California requires that we notify you that we will pay interest if we have not processed the claim within 30 days after the date of death. Interest will be paid at the rate of interest for proceeds left on deposit with the company.

For policies issued in New Hampshire*:

The state of New Hampshire requires that we notify you that we will pay interest if we have not processed the claim within 30 days after the date of death. The rate of interest will be equal to the rate of interest under the interest settlement option shown in the policy.

For beneficiaries who are residents of New Jersey:

The state of New Jersey requires that we notify beneficiaries that information regarding death claim payments is being supplied to the state pursuant to requirements of the New Jersey Division of Taxation and that it is the position of the Division of Taxation that a beneficiary or beneficiaries may, in the absence of state or federal statutes to the contrary, be personally liable for any and all inheritance and/or estate taxes until paid.

For policies issued in Oregon*:

If we fail to pay the proceeds of or make payment under the policy within 30 days after receipt of due proof of death and proof of the interest of the claimant, we will pay interest on any money due. Interest will be paid from the date of the insured's death until the date of payment, at a rate not lower than what we pay on policy loans.

For policies issued in South Dakota*:

The state of South Dakota requires that we notify you that we will pay interest from the date of death on the proceeds payable under this policy. Interest will be paid at the interest settlement option rate in the policy, or four percent, whichever is greater.

**Policies issued under the Interstate Insurance Product Regulation Commission (IIPRC) may have a different interest rate. Refer to the policy for more information.*

AGENT: **DETACH** HERE



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CLAIM FRAUD WARNING STATEMENTS

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.
The laws of the states below require the company to provide the following state specific statements:
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.
Arkansas, Louisiana, Massachusetts, Rhode Island and 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.
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 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.
Delaware – 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.
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.
Idaho – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.
Indiana – A person who knowingly and with the intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
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.
Maine, Tennessee, Virginia and 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.
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 FINES AND CRIMINAL 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 fact 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.
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.
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.