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

If you need assistance filing your claims, please contact us at 888-212-6970 or *life-healthclaims@cinfin.com*

Please review the checklist below prior to submitting your claim:

- ☐ **Death Certificate:** A certified copy of the death certificate, including cause and manner of death, must be provided to us.

- ☐ **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.
  - ☐ **Policy Information:** In Section A, list all policies for which you are claiming a benefit and provide the insured's information.
  - ☐ **Claimant/Beneficiary Information:** Complete Section B in its entirety.
  - ☐ **Payment Options:** Review the information in Section D and mark which one you prefer.
  - ☐ **Tax Identification Number:** In Section E, all claimants must provide their Social Security Number or Employer, Tax, Trust or Estate Tax ID Number. Complete the certification ensuring the number is correct and indicating whether you are subject to backup withholding. If this section is not complete, we are required to withhold taxes on any interest earned on the death claim proceeds.

- ☐ **Policy:** Please send the policy to us. If it has been lost, check the box in Section C of the Claimant's Statement.

- ☐ **Authorization to Release Medical Information:** Section F must be completed if the insured died within two years of the date the policy was issued or reinstated, or if the cause was accidental and you are claiming those benefits.

Additional requirements may be requested by Life Claims

Return completed forms to: The Cincinnati Life Insurance Company
Life Claims
P.O. Box 145496
Cincinnati, OH 45250

Life-HealthClaims@cinfin.com ■ Phone: 888-212-6970 ■ Fax: 513-870-2969

Forms included:
- Claimant's Statement Form CLI-8695 (8/23)
- 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

The Cincinnati Life Insurance Company
P.O. Box 145496, Cincinnati, Ohio 45250-5496

CLAIMANT'S STATEMENT

Instructions:

- ► Complete all applicable sections.
- ► Each beneficiary must submit a separate form.
- ► If the primary beneficiary is deceased, please submit a copy of his or her death certificate.
- ► If death occurred outside the United States, please submit the official death certificate issued in the country where death occurred and a completed Report of a Death of a U.S. Citizen Abroad.
- ► If policy is being assigned, attach a notarized assignment form (available from the funeral home) and an itemized copy of the funeral bill. A separate check for the amount of the assignment will be mailed directly to the funeral home.

  Is policy being assigned to a funeral home? ☐ Yes ☐ No

Section A. Policy 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: __________

Cause of Death: ____________________
If an Accidental Death claim is being filed, attach newspaper clippings and police report.

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	Dates Treated	Disease or Condition

Use additional sheets if necessary.

Section B. Claimant/Beneficiary Information

Special Instructions:

- ► If an attorney-in-fact under a Power of Attorney is filing on behalf of the beneficiary, a copy of the Power of Attorney must be provided.
- ► If the beneficiary is an Estate, the Claimant's Statement must be completed for the Estate by the executor or administrator of the Insured's Estate and must be signed by the Executor as Claimant. A certified copy of the Letters of Administration appointing the executor or administrator should also be attached.
- ► If the beneficiary is a minor, the Claimant's Statement must be completed by the guardian of the minor's Estate and copies of the letters appointing guardianship must be submitted.
- ► If the beneficiary is a former spouse, include a copy of the divorce decree and the property settlement.
- ► If the beneficiary is a trust, the Claimant's Statement must be completed for the trust and signed by the trustee and a trustee certification is required.

THIS SECTION MUST BE FULLY COMPLETED

Claimant/Beneficiary Name: ______________________________

Also Known As: ______________________________
(Nicknames, maiden name, etc.)

Date of Birth: ____________________ SSN or TIN: ____________________

Name of Trustee or Estate: ____________________ Date of Trust: ____________________
(if named as beneficiary)

Mailing Address: ______________________________

City, State, ZIP: ______________________________

Email Address: ______________________________

Telephone Number: ____________ ____________ ____________
Home Work Cell

Relationship to Insured: ____________________ Best Time to Call: ____________________

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 Claimant/Beneficiary Date

______________________________ ____________________
Print Name of Claimant/Beneficiary Relationship (i.e. Spouse, Child, Trustee, etc.)

Section C. Statement of Policy Loss

☐ **Check this box if policy cannot be located.**
If the policy is later found, I agree to surrender it to the company without claim.

The Cincinnati Life Insurance Company
P.O. Box 145496, Cincinnati, Ohio 45250-5496

Section D. 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:** If elected, choose one of the lump sum options. For Electronic Funds Transfer, include a voided check. If proceeds are payable to a minor, corporation, estate or trust, payment will be made via check.

☐ Payment via check ☐ Payment via EFT (voided check attached)

☐ **Settlement Option:** Three settlement options are described below. Please refer to the policy to determine if these or other options are available. If you have questions regarding settlement options, you may contact Life Claims at 888-212-6970 to speak with a claim processor.

1. **Income for Fixed Period:** Payments will be guaranteed for the number of years chosen, not to exceed 30 years. The income is determined from the table for this option located in the policy.

   Number of years: ____________

2. **Income of Fixed Amount:** We will make equal payments of the amount chosen. These payments will be made until the amount left under the Option, with interest, is exhausted. The last payment will be for the balance only.

   Amount per payment: ______________________

3. **Life Income with Guaranteed Period:** We will pay an income for a guaranteed period as elected. The income and guaranteed period are determined by the table for this option in the policy.

Indicate settlement option you choose: ___________________________________

Choose Payment Frequency: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly

I hereby acknowledge that I have read the information about the payment options available and have selected one of the above options as a means of receiving payment of proceeds due from a life insurance policy from The Cincinnati Life Insurance Company.

____
Signature of Claimant

____ ___________________________________
Print Name of Claimant Date

Section E. Request for Taxpayer Identification Number and Certification

The Internal Revenue Service requires that you provide The Cincinnati Life Insurance Company with your correct Social Security Number or Tax Identification Number. We may have to withhold, and send to the IRS on your behalf, a portion of any interest due to you; unless you provide us with the correct Social Security Number, and state that you have not been notified that you are subject to an IRS backup withholding order on interest and dividends.

Social Security Number:	OR	**Employer, Trust, or Estate Tax ID Number:**
____________________		________________________________

☐ Check this box if you are not a U.S. citizen or U.S. resident for tax purposes and complete form W-8BEN instead of completing the remainder of this section.

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.

NOTE: Cross out number 2 above 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.

____ ____________________
Signature of Claimant Date

____
Print Name of Person/Party Signing

____
Relationship to Insured

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Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
cinfin.com ■ 513-870-2000

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: ______________________________ Policy number(s) ______________________________
Month Day Year

______________________________ ______________________________
Print Name of Insured or Personal Representative Signature of Insured or Personal Representative

____
Relationship to Insured
(indicate if Personal Representative)

Form CLI-8513 (9/21)

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Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
cinfin.com ■ 513-870-2000

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.

AGENT: **DETACH** HERE

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 statues 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.*

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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.