INSTRUCTIONS FOR FILING A DEATH CLAIM

To file a death claim you will need to return the Claimant's Statement with a certified copy of the Death Certificate indicating the cause of death and if the claim is being filed within two years of the contract issue date, the HIPAA Authorization.

We offer several convenient ways to return information:

Online:
1. To send documents, go to https://l.usaa.us/Claims_upload
2. Enter credentials
3. Select Life & Health Insurance/Annuities

Fax: 877-435-7099
Mail:

ATTN: Life Company Claims
USAA Life Insurance Company
USAA Life Insurance Company of New York
9800 Fredericksburg Road
San Antonio, TX 78288

If you have any questions or need assistance in filing a Life/Annuity death claim, please call 800-531-8455.

INSTRUCTIONS ONLY
DO NOT RETURN THIS PAGE

USAA Life Insurance Company
USAA Life Insurance Company of New York
Service Center
9800 Fredericksburg Road
San Antonio, TX 78288

LIFE INSURANCE CLAIMANT'S STATEMENT

Full Name of Deceased	USAA Number	Contract Number

Date of Birth	Name of Last Employer	Business Phone ( )
Date of Death	Cause of Death	

Has this policy been pledged as collateral for a loan? If yes, with whom?

Children of Deceased who are now living:

Name	Date of Birth	Name	Date of Birth

Other insurance in effect:

Company Name _____ Policy Number _____

City State

LIST ALL HEALTH INSURANCE CARRIERS DURING THE PAST FIVE (5) YEARS.

Name _____ Policy Number _____ Effective Dates _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Name _____ Policy Number _____ Effective Dates _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

LIST ALL PHYSICIANS OR PRACTITIONERS CONSULTED IN THE PAST FIVE (5) YEARS INCLUDING HOSPITAL CONFINEMENTS.

Name _____ Phone _____ Dates Consulted _____ Reason for Consultation _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone _____ Dates Consulted _____ Reason for Consultation _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone _____ Dates Consulted _____ Reason for Consultation _____

Address _____ City _____ State _____ Zip _____

See page 2 - SIGNATURE REQUIRED

New York Residents: 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.

SIGNATURE OF CLAIMANT I represent the information on this form is true and complete and I understand that such information will be used by USAA LIFE INSURANCE COMPANY/USAA LIFE INSURANCE COMPANY OF NEW YORK for the purpose of evaluating a claim for insurance benefits.

Signature of Beneficiary (Claimant) Date Date of Birth SSN/Tax Identification #

Citizenship: ☐ U.S ☐ Resident Alien ☐ Non-Resident Alien

Specify Country if other than U.S.*: _____

Print name of Beneficiary or Authorized Representative USCIS # (formerly Resident Alien No): _____

*If you are not a U.S. Person (including resident alien) or US Entity, submit the applicable Form W-8 (BEN, BEN-E, CE, ECI, EXP OR IMY)

Beneficiary's mailing address City State Zip Code Phone Number

Is your mailing address the same as your physical address? ☐ Yes ☐ No

If no, what is your physical address (cannot be a P.O. Box or Route).

Beneficiary's physical street address City State Zip Code

IMPORTANT INFORMATION: Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Tax Certification For Beneficiary

Substitute IRS Form W-9

NOTE: The following certification is required by the Internal Revenue Service (IRS) and does not affect your insurability**.**

Applicable to U.S. persons (including U.S. citizens and resident aliens), If you are not a U.S. person, you are required to submit the applicable IRS form W-8 series (BEN, BEN-E, ECI, EXP or IMY).

Under penalties of perjury, I certify to the following:

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 (defined below); and

4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Signature of Beneficiary (Claimant) Date

Certification of Trust.
Complete this Section if Beneficiary is a Trust.

Name of Trust: _____ Date of Trust: _____ Date Amended: _____

I certify as follow:

1. I / We are trustee(s) under Trust named above.
2. I / We as trustees designated as beneficiary under the above numbered policies.
3. The Trust Agreement named above is in full force and effect and by its terms Trustee(s) are empowered to receive payment of the proceeds of the above policy(ies).

It is understood and agreed by the undersigned the payment of such proceeds to the Trustee(s) shall discharge the Company from any and all liability.

Signed this _____ day of _____ ,20 _____

_____
All co-trustees must sign and date

ILLINOIS ISSUED CONTRACTS INFORMATION FOR CLAIMS ASSISTANCE

Illinois Interest Statement - If payment is not made within 31 days after receipt of the due proof of death, interest on the claim settlement will accrue at the rate of 10% from the date of death to the date of payment for the total amount payable. The due proof of death includes but is not limited to the date the death certificate is received, documentation sufficient to determine the company's liability, and if applicable any necessary legal impediments to the payment of the death proceeds that depends on the action of parties other than the company are resolved.

Fraud Warning Disclosure
Please keep for your records

NOTICE	Under applicable state law, any person who knowingly files a claim containing false or misleading information or who conceals information with intent to defraud or mislead an insurance company or other person, may be guilty of a felony or subject to other criminal and/or civil penalties including denial of insurance benefits.
ALABAMA RESIDENTS	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 RESIDENTS	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/ DISTRICT OF COLUMBIA/ LOUISIANA/ RHODE ISLAND/ WEST VIRGINIA RESIDENTS	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 RESIDENTS	For your protection Arizona law requires the following statement 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 RESIDENTS	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 RESIDENTS	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 RESIDENTS	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 RESIDENTS	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 RESIDENTS	Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.
INDIANA RESIDENTS	A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
KENTUCKY RESIDENTS	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/ WASHINGTON RESIDENTS	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 RESIDENTS	Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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 RESIDENTS	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 RESIDENTS	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 RESIDENTS	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO RESIDENTS	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 RESIDENTS	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 RESIDENTS	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 RESIDENTS	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 RESIDENTS	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.

For claims assistance, please call USAA LIFE INSURANCE COMPANY/USAA LIFE INSURANCE COMPANY OF NEW YORK toll free 800-531-8455. In San Antonio 210-456-9013.

HIPAA AUTHORIZATION CONCERNING MEDICAL AND FINANCIAL INFORMATION

Name of Deceased:_____

I understand that the information released through this authorization will be used by USAA Life Insurance Company to conduct a prompt and thorough claim investigation. I understand that although this authorization is voluntary, USAA Life reserves the right to decline my claim for benefits if I refuse to grant this authorization.

The information released pursuant to this authorization may no longer be protected by federal privacy regulations. USAA Life will not release identifiable health information obtained by use of this authorization outside of USAA Life, except to its reinsurers, the Medical Information Bureau (MIB), other persons or organizations performing administrative or legal services related to this claim for insurance benefits and as required by law.

I authorize the following persons and organizations, who may have knowledge of the deceased's health, activities, work, employment and financial affairs, to provide information to USAA Life Insurance Company ("USAA Life") or any investigative service or other agent acting on its behalf or an agent, attorney, consumer reporting agency or independent administrator acting on its behalf: (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veterans Administration clinic, or medically-related facility; (f) MIB; (g) pharmacies and pharmacy benefit managers; (h) any psychiatrist or psychologist; (i) any health facility; (j) any consumer reporting agency; (k) any past or present employer; (l) individuals or organizations with knowledge regarding income and earnings, tax payments or other medical or financial information relevant to the deceased.

For purposes of this Authorization, "information" means any printed or electronic records or unrecorded knowledge concerning the deceased.

This authorization includes the release of the entire medical record of the deceased including information about AIDS, HIV, drugs, alcoholism, or mental illness. This authorization allows USAA Life to obtain any medical records or information that are subject to a request for additional restriction of use and disclosure pursuant to the privacy rights granted by the Health Insurance Portability and Accountability Act.

To facilitate rapid submission of the information requested, I authorize all sources to give such records or knowledge to any agent employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be valid as the original. I agree that this Authorization shall be valid for one (1) year from the date shown below, and that upon request, I or my authorized representative is entitled to receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request referencing the USAA number and the date of this Authorization to USAA Life . A revocation does not affect any actions taken by USAA Life in reliance on the Authorization prior to receipt of the revocation and may impair my ability to receive benefits from this claim.

For Oklahoma residents, the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

_____

Signature of Claimant, Authorized Representative or next of kin

_____

Date

_____

Relationship to Deceased

For claims assistance, please call USAA LIFE INSURANCE COMPANY Toll Free at 800-531-8455.

Please retain a copy of this signed authorization for your records

MAIL TO: ATTN: Life Claims
USAA LIFE INSURANCE COMPANY
9800 Fredericksburg Road
San Antonio, Texas 78284-8499