

Life Claim Information Sheet

See the back of this form for instructions/definitions.

This form **must** be completed by the employer when reporting a waiver of life insurance premium claim, accelerated life claim, or the death/dismemberment of an employee or covered dependent. The following documents **must be attached** to this *Life Claim Information Sheet* when sent to the HCA:

- 1) **All** original life insurance enrollment form(s) (copies, if an original is not available).
- 2) Original certified death certificate, if submitting a death claim.

Employee Information (must be completed)					
Agency Code		Agency Name			
Social Security Number — —		Last Name		First Name	
M.I.		Address		City	State
ZIP + 4		Date of Birth (Mo/Da/Yr) — —		Employee's Home Phone Number ()	
Current Agency Hire Date — —		Original Hire Date (unbroken service date) — —		Original Insurance Eligibility Date (first day of eligibility with state service) — —	
Last Day Physically on the Job — —		Current Job Title		Monthly Salary as of Last Day Physically on the Job Amount \$	
Date of Last Salary Change (prior to last day physically on the job) — —		Salary Prior to Last Increase Amount \$ Per			
Type of Claim					
<input type="checkbox"/> Life Waiver <input type="checkbox"/> Accelerated Life Claim <input type="checkbox"/> Death Claim <input type="checkbox"/> Dismemberment Claim					
Name of Deceased or Injured Person				Relationship to Employee	
Date of Illness/Injury/Death (Mo/Da/Yr) — —		If a Dependent, Date of Birth — —		Dependent's Social Security Number — —	
Part A-Basic Amount \$		Part A-Basic AD & D Amount \$		Part B-Basic Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$	
Part B-Basic Dependent <input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$		Part B-Supplemental Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$			
Part C-Optional <input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$		At Maximum? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Part D-Supplemental <input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$		Part E-Voluntary AD & D <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Without Dependents <input type="checkbox"/> With Dependents Amount \$		Retiree Term Life <input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$	
Beneficiary Name		Date of Birth (Mo/Da/Yr) — —		Relationship to Employee	
Beneficiary's Social Security Number — —		Address			
City		State	ZIP + 4		Beneficiary's Phone Number ()
Name of Person Completing This Form		Phone Number ()		Date — —	

Mail completed form to: Health Care Authority • P.O. Box 42684 • Olympia, WA 98504-2684

Life Claim Information Sheet

Instructions/Definitions

LIFE WAIVER: Claims should be filed if an employee is under 60 years old on his or her last day physically on the job (**even if the employee has been terminated or has resigned**) and the employee will be unable to work for six months or longer due to a disability or illness, or at the employee's or Health Care Authority's (HCA) request.

Complete the *Life Claim Information Sheet*. Be sure to include **all original life enrollment form(s)**; i.e., all life forms that the employee has completed within state service. (If originals are not available, include copies. If copies are not available, provide proof of payment of premiums for life coverage from the effective date.)

CURRENT AGENCY HIRE DATE: First day of employment with your state agency, political subdivision, K-12 school district, educational service district, or higher education institution.

ORIGINAL HIRE DATE: First day of employment with a state agency, political subdivision, K-12 school district, educational service district, or higher education institution, even if the employee was not eligible for benefits.

ORIGINAL INSURANCE ELIGIBILITY DATE: First day employee became eligible for insurance benefits.

LAST DAY PHYSICALLY ON THE JOB: Last day the employee physically worked (**not** the last day in pay status) or had hours reduced or duties modified because of a disability. Employees may use their sick leave, annual leave, shared leave, and Family and Medical Leave Act (FMLA) leave after their last day physically on the job.

RETURN TO WORK (RTW): If an employee returns to work **before** an LTD claim is filed, the HCA needs to know whether the employee returned to work in a full-time, part-time, light duty, restricted duty, or regular duty status.

MONTHLY SALARY: Monthly wages as of the employee's **last day physically on the job**, or the date the employee's hours were reduced or duties were modified because of a disability.

DATE OF LAST SALARY CHANGE: Date the employee's wages changed **before** the employee's last day physically on the job, or the date the employee's hours were reduced or duties were modified because of a disability.

ACCELERATED LIFE CLAIM: Employee **must** send a letter to the HCA requesting that the claim be filed.

DISMEMBERMENT: Actual date of injury.