INSTRUCTIONS FOR COMPLETING THE CLAIM FORM

- The claim form must be completed by the person to whom the insurance is payable
- Complete Sections 1, 2, and 4 for **all** death claims.
- Complete Section 3 if any policy was issued within two years of the date of death.
- If Section 3 is completed, the HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION form must also be completed. The Company reserves the right to obtain further information should it be deemed necessary.
- If the amount payable is to be divided among several beneficiaries, a separate claim form must be completed by each beneficiary.
- If the beneficiary is a minor, the claim form is to be completed by the minor's legally appointed guardian, a certificate of whose appointment and authority must be furnished along with the completed forms. In such case, a separate beneficiary form must be completed for the minor **and** the legal guardian information. Both must sign the forms, if possible.
- When the policy proceeds are payable to "children" or others of a class, names being specified, a sworn statement must be furnished, giving names and dates of birth for each; and if any died without a will, unmarried and without children.
- When policy proceeds are payable to the estate of the insured, this statement must be made by an executor or administrator, a certificate of whose appointment and authority must be furnished.
- When the policy has been assigned, the assignee must provide a statement to the company advising the company of the assignment and attaching the original assignment. If the assignment is not meant to be an absolute assignment of a complete interest in the policy, then a statement must be completed by the assignee and the beneficiary making that intent clear. If separate checks are desired, then the assignee and the beneficiary must make such a request for separate checks together.
- When the policy proceeds are payable to someone who dies before the Insured, a certified death certificate issued by the State Bureau of Vital Statistics must be furnished, giving the place and date of death of the deceased person. This requirement may be disregarded when the company has received prior claim on such person.
- When policy proceeds are payable to a corporation or firm, this statement must be made by a duly qualified officer who has the power and right to make such claim in the name of the corporation or firm.
- In addition to completing the Life Claim form, please furnish:
  - Official death Certificate, original certificate with raised seal.
  - The Policy. If the policy (ies) is (are) lost or destroyed, you must so certify on a separate sheet of paper.
  - Evidence of change of name of insured or beneficiary (if applicable).
  - If death was violent or accidental, please also include the following in addition to the foregoing: autopsy, toxicology, and police reports; a certified copy of the coroner's report; and newspaper accounts and articles.

P.O. Box 470608 • Cleveland, Ohio 44147
(440) 922-5160 • Fax (440) 922-5152

LIFE CLAIM FORM

Policy # _______________

SECTION 1: INFORMATION ABOUT THE DECEASED-COMPLETE FOR ALL CLAIMS

Last Name	First Name	M.I.	Maiden Name / Nickname
Street Address	City	State	Zip Code

Date of Birth ________/_________/__________ Month Day Year	Age	Sex ☐ Male ☐ Female	Social Security #

Marital Status ☐ Single ☐ Married ☐ Widow / Widower ☐ Separated / Divorced

Date of Death ________/_________/__________ Month Day Year	☐ Yes ☐ No Other Life Insurance (If yes, please list)		
Employer Name	Complete Address	State	Phone Number ( )

SECTION 2: CAUSE OF DEATH ☐ **Check to confirm that certified copy of death certificate is enclosed. A death certificate is required in order to process all claims. If the death was from a reason other than natural causes, include a police/accident report and any news articles.**

☐ Natural	☐ Accident	☐ Homicide	☐ Suicide

DESCRIBE SPECIFIC DETAILS: Attach a separate sheet of paper if additional space is required

SECTION 3: PHYSICIAN INFORMATION - List all treating physicians / hospitals in the last 5 years.

Use separate sheet of paper if additional space is required

Family Physician Name	Complete Address	State	Phone Number ( )
Physician or Hospital Name	Complete Address	State	Phone Number ( )
Physician or Hospital Name	Complete Address	State	Phone Number ( )
Physician or Hospital Name	Complete Address	State	Phone Number ( )

P.O. Box 470608 • Cleveland, Ohio 44147
(440) 922-5160 • Fax (440) 922-5152

PRINT CLEARLY

SECTION 4: BENEFICIARY INFORMATION- To be completed and signed by each beneficiary

Last Name		First Name	M.I.	Maiden Name / Nickname
Address		City	State	Zip Code
Date of Birth ______/_______/_______ Month Day Year	Age	Sex ☐ Male ☐ Female	Social Security #	
Relationship to the deceased ☐ Child ☐ Parents ☐ Spouse ☐ Other ____________				
Phone Number Day ( )		Evening ( )		

Federal Law Requires this Information:
We may have to withhold and send to the IRS on your behalf 28% of certain reportable payments you may be entitled to, unless we have your correct social security number, and you state that you have not been notified that you are subject to an IRS Back-up Withholding Order on interest and dividends.

☐ I **have not** been notified by the IRS that I am subject to a Back-up Withholding Order on interest and dividends.
☐ I **have** been notified by the IRS that I am subject to Back-up Withholding Order on interest and dividends.

For your protection, certain state laws require the following to appear on this form:
WARNING: Any person who knowingly and with intent to injure, defraud, or deceive 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.

In addition, any person who commits such a fraudulent act (or facilitates the act):

- may be prosecuted under state law (Alaska residents only)
- may be subject to fines and confinement in prison (Arkansas, California, and New Mexico residents only)
- **is subject to penalties that may include imprisonment, fines, denial of insurance, and civil damages (Colorado residents only). Also, any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.**
- is guilty of a felony (Delaware, Idaho, Indiana, and Oklahoma residents only).
- is guilty of a felony in the third degree (Florida residents only).
- may be subject to penalties including imprisonment, fines or denial of insurance benefits (Maine residents only).
- may be guilty of insurance fraud (Maryland residents only).
- is subject to prosecution and punishment for insurance fraud as provided in RSA638-20 (New Hampshire residents only).
- 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 (New York residents only).

It is a crime to knowingly provide false, incomplete, or misleading information to and insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits (Virginia residents only).

Any person who knowingly and with intent to defraud any insurance company or 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 (Pennsylvania residents only).

X____________________________________ X________________________
Beneficiary's Signature **Date**

X____________________________________ X________________________
Legal Guardian Signature (If Beneficiary is a minor) **Date**

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize any health care professional, hospital, Veterans Administration, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, insurance company, insurance support organization such as MIB), or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (collectively, "My Providers") to disclose my entire medical record, medication history, and any other protected health information concerning me to **Family Heritage Life Insurance Company of America, or its designee,**

This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STDs.) This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that **Family Heritage Life Insurance Company of America** may: (1) obtain reinsurance; (2) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (3) administer coverage; and (4) conduct other legally permissible activities that relate to any coverage I have or have applied for with **Family Heritage Life Insurance Company of America.**

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Family Heritage Life Insurance Company of America, P.O. Box 470608, Cleveland, Ohio 44147, Attn: Life Policy Claims. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization or to the extent that **Family Heritage Life Insurance Company of America** has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal rules governing privacy and confidentiality of health information. However, **Family Heritage Life Insurance Company of America** will protect the privacy of health information in accordance with other applicable state and federal privacy laws and their own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refused to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, **Family Heritage Life Insurance Company of America** may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that I am entitled to a copy of this signed authorization.

Signature of Personal Representative **Date**

Description of Personal Representative's Authority or Relationship to Patient
(For death claims, please attach copy of appointment of executor of estate.)