Essential StaffCARE®

Term Life/Accidental Death Claim Form

Mail claims to PAI, P.O. Box 6702, Columbia, SC 29260-6702

Section 1. Employer's Statement

Employee's Name:_____
Last First Middle

Employee's Birth Date:_____ Employee's SSN:_____

Address:_____
Street City State Zip

Deceased's Name:_____
Last First Middle

Date of Death:_____ Deceased's Relationship to Employee: _____

BCS Life Insurance Group Policy No._____Certificate No. _____

BCS Life Insurance Group Policy Effective Date for Employee: _____ Date to which premium is paid:_____

Date Employed:_____ Employee's Occupation:_____

Was employee at work on above coverage effective date? ☐ Yes ☐ No

Amount of Insurance: BASIC: $ _____ SUPP: $ _____ AD: $ _____

Amount of Salary: $ _____ Per ☐ hour ☐ week ☐ month ☐ year

Date employee last reported for work:_____

Reason for employee stopping work: ☐ Deceased ☐ Illness ☐ Injury ☐ Other:_____

☐ Laid-off ☐ Terminated ☐ Vacation ☐ Retired Date: _____

I certify that the above information is correct based on our records. The information above and any accompanying documents and statements of all the physicians who attended or treated the deceased and all other papers required shall be part of the proofs of claim. The furnishing of this or any related form is not an admission that any insurance was in force on the date of death, nor a waiver of any rights or defenses.

Name of Employer/Company:_____ Telephone: _____

Signed by:_____ Date: _____

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Section 2. Beneficiary's Statement

• If there is more than one beneficiary, each beneficiary must complete a copy of this section.

• A certified copy of the death certificate must be attached to the completed form. • If claim is also made for Accidental Death benefits, beneficiary must complete the reverse side.

Beneficiary's Full Name:_____ SSN:_____
Last First Middle

Address: _____
Street City State Zip

Birth Date:_____/_____/_____ Daytime Telephone:_____ Relationship to Deceased: _____

Important Tax Notice

Under Federal Tax law, the Company is required to ask you to certify your correct Taxpayer Identification Number (TIN) and to include it in any reports of taxable income it makes to the IRS. If you are an individual, your Social Security number is your Taxpayer Identification Number.

Certification: I certify that I am not subject to backup withholding (Section 3406(a)(1)(c) of the Internal Revenue Code), and I am a U.S. person (including a U.S. resident alien). I also certify that the Taxpayer Identification Number on this form is true, correct and complete.

The Internal Revenue Service does not require your consent to any provisions of this document other than the certifications required to avoid backup withholding.

Beneficiary's Signature:_____ Date: _____

Section 3. Authorization

Occasionally, in the processing of a claim it becomes necessary for the insurance company to contact an outside source for additional information. If this occurs, having the legal representative or next of kin sign the authorization below now may expedite processing of this claim.

To physicians, hospitals, medical service providers, pharmacist, employers, consumer reporting agencies, law enforcement agencies, and any other agencies for organizations (including other insurance companies, BlueCross BlueShield, self-insured, and prepaid health plans) and specifically _____Hospital(s) and Dr.(s)_____.

You are authorized to permit BCS Life Insurance Company and its authorized representatives to view and obtain a copy of ALL RECORDS subject to any limitations indicated below*, including employment, law enforcement, financial, insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric, drug or alcohol treatment and disease of:

Print name of Deceased:_____

I understand the information obtained will only be used by BCS Life Insurance Company to determine eligibility for insurance and benefits claims under the Deceased's policy. I consent to redisclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organizations performing business or legal services in connection with this claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in the form without my written consent.

I understand that this authorization may be revoked by written notice to BCS Life Insurance Company, but this will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date it is signed.

I know that I may request a copy of this authorization. I also agree a photocopy of this authorization shall be as valid as the original.

*Limitations, if any:_____.

Signature_____ Relationship to Deceased_____ Date_____

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Section 4. Beneficiary's Statement for Insured's Accidental Death

Please attach any newspaper articles, accident reports, autopsy report, and other documentation to support your claim. Also, please provide the following information:

Insured's Name:_____
Last First Middle

Insured's Address:_____
Street City State ZIP

Insured's Occupation at Time of Death:_____ Date of Employment at this Place: _____

Date and Time of Accident Causing Death: _____ _____ ☐ a.m. ☐ p.m.

Date and Time of Death: _____ _____ ☐ a.m. ☐ p.m.

Place of Accident: ☐ At Work ☐ Recreation ☐ Highway ☐ Home ☐ Other:_____

Describe Accident in Detail:_____

_____

_____

Give Names and Addresses of Witnesses (attach separate sheet if necessary)

Name	Address

If automobile accident, was insured: ☐ Driver of Vehicle ☐ Passenger ☐ Pedestrian

Did this accident occur in the course of the insured's usual occupation? ☐ Yes ☐ No

If yes, has workers' compensation claim been presented? ☐ Yes ☐ No

What injuries were sustained?_____

Was immediate first aid sought? ☐ Yes ☐ No If yes, give name and address of:

Doctor:_____

Hospital:_____

Other:_____

Was accident reported to police or other official agency? ☐ Yes ☐ No If yes, give name and address of department or agency:

_____

Was an autopsy performed? ☐ Yes ☐ No If yes, please attach a copy of the report.

Autopsy performed by:_____ Date Performed:_____

Address:_____
Street City State ZIP

Names and addresses of all physicians or practitioners who treated insured in last three years.

Name	Address (Street, City, State, ZIP)	Date Treated	Condition Treated

With what companies and in what amounts was life of deceased insured?

Name of Company	Policy Date	Amount	Accidental Death Benefits
			☐ Yes ☐ No
			☐ Yes ☐ No

Beneficiary's Signature:_____ Date:_____

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Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

The laws of some states require us to furnish you with the following notices:

WARNING. Any person who knowingly:

Alaska: 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.

Arizona and Arkansas: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or specific to AR: presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California, Louisiana, New Mexico and Texas: presents a false or fraudulent claim for the payment of a loss or benefit (or specific to LA and TX: who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or specific to NM: to civil fines and criminal penalties.)

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Florida: and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or 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, specific to PA: subjects such person to criminal and civil penalties and specific to NY: 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 Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: 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: 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.

WARNING:

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, Tennessee and Virginia: It Is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company, (or specific to DC: 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.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine: 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.

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.