PACIFIC LIFE

Accelerated Benefit Option

Employee/Member Claim Statements Package

This package is to be used by an Employee/Member who wants to file a claim for an Accelerated Benefit Option after being diagnosed with a terminal illness and having less than 12 months to live.

The following forms are required:

- Group Life Insurance - Accelerated Option Claim Statement Instructions
- Accelerated Benefit Option Employee Claim Statement
- Authorization for the Use and/or Disclosure of Information
- Claim Fraud Statements
- Accelerated Benefit Option Employer Statement
- Attending Physician Statement for Accelerated Benefit Option

Pacific Life & Annuity Company
Workforce Benefits
PO Box 2387
Omaha NE 68103-2387
PH (855) 810-3301 Fax (949) 219-8872
claims.workforcebenefits@pacificlife.com

Group Life Insurance - Accelerated Benefit Option Employee Claim Statement Instructions

Pacific Life is here to support you during this process. If you have any questions regarding this form or documentation required, please reach out to us at (855) 810-3301 during the hours of 8 a.m. through 8 p.m. Eastern Time.

An Accelerated Benefit Option is a one-time payment of a portion of in force life insurance benefits. An insured can qualify for the Accelerated Benefit Option by being terminally ill with a shortened life expectancy of typically 12–24 months or less (refer to your certificate for specific life expectancy requirements). Payment of an Accelerated Benefit Option will reduce the life insurance amount by the amount of the benefit received.

Claim Submission Instructions:

1. Complete the **Group Life Insurance - Accelerated Benefit Option Employee Claim Statement**
   - Refer to your certificate for the amount of the life insurance benefit that can be accelerated when completing **Section 4**.
2. The information provided will be used to issue and mail any benefit payment made in association with this claim. Any benefit payments will be made by check.
3. Review the fraud notices and sign the completed form where indicated.
4. Your employer must complete and submit the **Group Life Insurance - Accelerated Benefit Option Employer Claim Statement**
5. Important additional documentation to submit with this form:
   - **Attending Physician Statement for Accelerated Benefit Option.** Your physician will need to complete and sign.
   - **Authorization to Obtain and Release Information**. This form will allow the request of any needed medical or other supporting documentation.
   - Supporting medical and/or hospital records that confirm the terminal illness.
6. The requested documents can be submitted to us via:
   - Email: claims.workforcebenefits@pacificlife.com
   - Mail: Pacific Life & Annuity Company, Attn: Workforce Benefits - Claims, PO Box 2387, Omaha, NE 68103-2387
   - Fax: (949) 219-8872

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Group Life Insurance - Accelerated Benefit Option Employee Claim Statement

Section 1: Employee/Retiree Information

(Note: The information provided below will be used to issue and mail any benefit payment made in association with this claim.)

Name (Last, First, MI Suffix):	Date of Birth (MM/DD/YYYY):	Social Security Number:
Address:	City:	State: ZIP Code:
Telephone Number:	Email:	Marital Status:

Section 2: Employee/Retiree Medical Condition

Medical condition: _____

Date Symptoms were first noticed: _____ Date first treated: _____

Please indicate all physician(s) that have been seen for this condition.

Physician Name _____ Phone _____

Physician Address _____City _____ ST _____ ZIP _____

Physician Specialty_____

Physician Name_____Phone _____

Physician Address _____ City _____ ST _____ ZIP _____

Physician Specialty_____

Have you been hospitalized? ○ Yes ○ No If yes, please indicate dates hospitalized:

From _____ To _____ From _____ To _____ From _____ To _____

Hospital Name _____ Phone _____

Hospital Address _____ City _____ ST _____ ZIP _____

Are you required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise? ○ Yes ○ No

Have you assigned an irrevocable beneficiary or assignee to this policy? ○ Yes ○ No

Are you required by a government agency to use this benefit in lieu of applying for, obtaining, or otherwise keeping a government benefit or entitlement? ○ Yes ○ No

Section 4: Benefit Amount requested

Amount of Accelerated Benefit Option requested.

Basic Life: $ _____ Supplemental Life: $_____

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Section 5: Signature

By signing in the Signature section, I attest that:

- The answers provided in this Statement are true and complete to the best of my knowledge.
- I have read and understand the information in the Claims Fraud Statements section.
- The receipt of this accelerated benefit may be taxable.
- Receipt of the accelerated benefit may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income
- I understand any payments of the Accelerated Benefit Option will decrease the Life Insurance Benefit amount by the amount I receive.
- I understand that I may consult with an independent financial, tax or legal advisor, as needed. Pacific Life & Annuity Company will not provide me with any financial, tax, or legal advice or recommendations.

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATIONS REQUIRED TO AVOID BACK UP WITHHOLDING.

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 material 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: _____ Date: _____

Print Name: First, MI, Last (include Title/Capacity, if applicable) _____

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Authorization for the Use and/or Disclosure of Information

Claimant/Employee/Retiree Name: ..... DOB: .....

I authorize the use and disclosure of the following information so that Pacific Life & Annuity Company can evaluate the insurance claim on the above-named individual.

1. This authorization applies to the following information (whether from before, during or after the date of this authorization):

Any and all medical records: this includes, to the extent that the medical records include such information, information about HIV status, AIDS, other communicable or sexually transmitted diseases, mental health (other than "psychotherapy notes" that are kept separate from the medical record), any substance use disorder, and/or genetic information. Additionally, workers compensation information; postmortem examination, autopsy, toxicology records and reports; investigative reports; accident reports by law enforcement; paramedics records; employment incident reports; incident reports of any kind; photographs; insurance information; insurance claims records; financial and employment related information; and information regarding social security or other government benefits including benefit amounts and entitlement dates.

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of this information:

Health care professionals, hospitals, clinics, laboratories, pharmacies, emergency medical service agencies and all other medically related providers; medical examiner's offices, coroner's offices, health plans, insurance companies, third party administrators, law enforcement agencies, public safety departments, government agencies and entities (including to but not limited to federal, state, local and Social Security Administration), insurance producers, insurance service providers, credit bureaus, professional licensing bodies, consumer reporting agencies, reinsurers, employers, attorneys, financial institutions and/or banks.

3. I authorize the following persons (or class of persons) to receive this information:

Pacific Life & Annuity Company and its parent company.

4. Purpose of proposed use or disclosure:

For purposes of Pacific Life & Annuity Company evaluating and administering insurance claims.

5. I authorize Pacific Life & Annuity Company to share this information with:

The Group Insurance Plan as needed to perform its responsibilities under any benefit plan for the purpose of reporting claim status or experience, or so that the recipient may carry out health care operations, claims payment, administrative, or audit functions related to any benefit, plan or claim.

6. This authorization expires:

One year after the date of signature.

REFUSAL TO SIGN:

***You may refuse to sign this authorization**. A health care provider or health plan may not condition treatment, payment, enrollment, or eligibility for health plan benefits on your providing or refusing to provide this authorization. Your failure to sign this authorization, however, may result in Pacific Life & Annuity Company being unable to approve and pay this insurance claim.*

REDISCLOSURE:

Once your information is disclosed pursuant to this authorization, it may no longer be subject to federal and state law and may be subject to redisclosure. Pacific Life & Annuity Company will protect the privacy of this information in accordance with its privacy policy and other applicable law. For more information, you may visit https://www.pacificlife.com/home/privacy-and-other-policies/our-privacy-promise.html

REVOCATION:

You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to Pacific Life & Annuity Company at: PO Box 2387, Omaha, NE 68103-2387. Your revocation will not be effective to the extent that health care providers or health plans have already acted in reliance upon this authorization.

COPY OF AUTHORIZATION

You may request a copy of this authorization.

AUTHORIZATION

I understand and agree to the foregoing:

Signature ..... Date .....

Print Name .....

If signing as legal representative, describe your authority:

.....

Supporting Documentation must be attached.

....
Signature of Individual or Personal Representative Date

Printed name of Personal Representative .....

Relationship to Insured/Member .....

(e.g. LEGAL GUARDIAN, EXECUTOR, ADMINISTRATOR, OR NEXT-OF-KIN)

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Claim Fraud Statements

Please read the warning for your state.

General Fraud Warning: Any person who knowingly presents a false statement in a claim for insurance may be guilty of a criminal offense and subject to penalties under state law. (Not applicable in Virginia)

The laws of each state listed below require us to furnish you with the notice indicated below.

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 disclosure: 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.

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.

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.

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.

Maryland: 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.

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 CIVIL 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.

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.

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 and denial of insurance benefits.

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Group Accelerated Benefit Option Employer Statement

Section 1: Information about Employer and Employee:

Employer Name:	Policy Number:
Employer Address:	City: State: ZIP Code:
Name of Person Completing the Form:	Title of Person Completing the Form:
Telephone Number:	Email:

Section 2: Information about the Deceased

Employee Name (First, MI, Last):	Employee Social Security Number:	Date of Hire:	Effective Date of Employee Insurance:

Employment Status: ○ Full-time ○ Part-time ○ Retired ○ Exempt ○ Non-Exempt

Is Employee active at work? ○ Yes ○ No If No, date last worked: _____ (mm/dd/yyyy)	Employee's Premium Paid through date:	Employee Terminated? ○ Yes ○ No If No, date last worked: _____ (mm/dd/yyyy)	Insurance Class:	Location:
Date of Last Pay Increase:	Employee pay included? ○ Hourly - Per hour $ _____ ○ Salary – Annual salary $ _____		Check applicable: ○ Commissions ○ Bonuses ○ Overtime ○ Shift Differential	
Average Hours worked per Week:	Reason employee stopped working: ○ Illness ○ FMLA ○ Resigned/Dismissed ○ Retiree ○ Other:			

Section 3: Signature

Employer: I hereby verify that the information provided on this claim form is accurate and complete in accordance with employer records. I am authorized to provide this information on behalf of the employer.

Name: _____ Title: _____

Signature: _____ Date: _____

Telephone Number: _____ Email: _____

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Attending Physician Statement for Accelerated Benefit Option

The patient has requested an accelerated payment of life insurance benefits. Please provide the below information to help evaluate the claim.

Section 1: Information about the Patient (To be completed by patient)

Name (Last, First, MI):	Date of Birth (MM/DD/YYYY):	Social Security Number:
Phone Number:	Address:	

Section 2: Employee/Retiree Medical Condition

Primary Diagnosis include ICD or DSM code and Description: _____ Date of Diagnosis: _____

Secondary Diagnosis include ICD or DSM code and Description: _____ Date of Diagnosis: _____

Date of first office visit? (MM/DD/YY)	Most recent visit? (MM/DD/YY)	How often do you see this patient?

Symptoms resulted from?	When did symptoms first appear?	Has patient had the same or similar condition previously?
O Illness O Accident	_____	O Yes O No If yes, please describe. _____

Have you determined the condition is terminal? O Yes O No If yes, please provide the date the condition became terminal: _____

If yes, how many months is the life expectancy? _____ months

Objective Findings: (include copies of any X-rays, lab tests, EKG, MRI, scans, and office notes)

Have you referred the patient to other specialists/physicians: O Yes O No

Please indicate Name(s) and telephone number(s): _____

Has patient been hospital confined? O Yes O No

If yes, please provide details: _____

_____

Hospital(s):

_____

Address:

_____

Dates of Confinement: From _____ to _____ From _____ to _____

From _____ to _____ From _____ to _____

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Section 3: Signature of Attending Physician – The above statements are accurate and complete to the best of my knowledge and belief. Additionally, all supporting documentation on which the Physician's statement is based have been provided.

Physician Name:_____ Degree:_____ Specialty:_____

Address:_____ City:_____ State:_____ ZIP:_____

Telephone:_____ Fax:_____

Signature of Attending Physician:_____ Date:_____

Contact Person if any additional information is needed: _____

I have included the following:

O Lab results O Office Notes O MRIs O Scans O EKGs O X-rays O Other: _____

Please return this completed form and records by mail, fax, or email to:
Pacific Life & Annuity Company, Attn: Workforce Benefits – Claims, PO Box 2387, Omaha NE 68103-2387
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