PACIFIC LIFE

Accelerated Benefit Option

Employer Claim Statements Package

This package is to be used by Members/Employers who want 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 Benefit Option Employer Claim Statement Instructions
- Accelerated Benefit Option Employer Claim Statement
- Accelerated Benefit Option Employee Claim Statement
- Authorization for the Use and/or Disclosure of Information
- Authorization for Release of Claim Information
- Claims Fraud Statements
- 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 Employer 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:

When filing a claim for the Accelerated Benefit Option, please provide the following:

1. Complete the **Group Life Insurance - Accelerated Benefit Option Employer Claim Statement**
   - Review the fraud notices in and sign the document
   - We may request payroll documentation to calculate the benefit per the earnings definition as defined in the policy
   - Make sure to complete each section about the employee.
2. Provide the employee with the following
   - **Accelerated Benefit Option – Employee Claim Statement**
   - **Attending Physician Statement for Accelerated Benefit Option**
   - **Authorization to Obtain and Release Information**
   - **Authorization for Release of Claim Information**
3. Please notify the employee that we will also require
   - Attending Physician Statement for Accelerated Benefit Option
   - Medical records and hospital records supporting the terminal condition.
   - Authorization for Release of Claim Information to contact medical providers (if necessary)
4. Return the documents to us at:
   - Email: claims.workforcebenefits@pacificlife.com
   - Mail: Pacific Life – Workforce Benefits Claims, PO Box 2387, Omaha, NE 68103-2387
   - Fax: (949) 219-8872

Employee documents can be submitted separately upon completion

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

Group Accelerated Benefit Option Employer Statement

Section 1: Information about Employer:

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 Employee

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: _____

Pacific Life & Annuity Company
Workforce Benefits - Claims
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

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: $_____

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

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) _____

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

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 2030, Omaha, NE 68103- 2030. 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)

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

Authorization for Release of Claim Information

I authorize Pacific Life & Annuity Company to release information regarding the following individual:

Claimant/Employee Name ……
(First) (Middle) (Last) (Suffix)

Date of Birth: …… Social Security Number: ……

I authorize release of medical, claim, benefit, and financial information relating to insurance benefits for the above identified individual, unless otherwise specified:

……

……

Information is to be released to the following named party for the purpose of assisting with the insurance claim of the above identified individual:

Name of Company or Individual: ……

Address: …… City: …… St: …… ZIP: ……

Telephone: …… Email: ……

This authorization will remain valid during the claim(s) duration, but not for more than one year from date signed.

I can revoke this authorization at any time by providing written notice to Pacific Life & Annuity Company by email, mail, or fax. I understand that to the extent that information has been previously released, such revocation may not be effective.

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

Signature …… Date ……

Print Name ……
First, MI, Last (include Title/Capacity and documentation, if applicable)

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

Claims Fraud Statements

Before signing the Beneficiary Claim Statement, 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 to appear on this form:

Any person who knowingly presents 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.

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.

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.

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

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

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

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

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

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

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

Has patient been hospital confined? Yes No

If yes, please provide details: _____

_____

Hospital(s)

_____

Address

_____

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

From _____ to _____ From _____ to _____

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

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:

○ Lab results ○ Office Notes ○ MRIs ○ Scans ○ EKGs ○ X-rays ○ 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
Fax (949) 219-8872
claims.workforcebenefits@pacificlife.com


PACIFIC LIFE