PACIFIC LIFE

Dismemberment

Employer Claim Statements Package

This package, for use by Employers, contains claim statements for dismemberment due to an accident. The following forms are required:

- Employer Instructions for Group Accidental Dismemberment Claim Statements
- Group Life Insurance - Accidental Dismemberment Claim Statement – Employer
- Group Life Insurance - Accidental Dismemberment Claim Statement - Employee
- Authorization for the Use and/or Disclosure of Information
- Authorization for Release of Claim Information (Optional)
- Claims Fraud Statements
- Group Life Insurance - Attending Physician Statement for Accidental Dismemberment

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

Employer Instructions for Group Accidental Dismemberment Claim Statements

Pacific Life is here to assist you and your employees submit claims as timely as possible. If you have questions about this statement or the documentation required, please call us at 855-810-3301 from 8 a.m. through 8 p.m., EST. We are here to support our members during this process.

If an insured employee or dependent has an event of dismemberment, please do the following:

Please complete the following steps:

1. Complete the Group Life Insurance - Accidental Dismemberment Claim Statement – Employer
   - Review the Claims Fraud Statements, then sign the document
   - If Accident is work related, please provide a copy of the injury report
   - We may request payroll documentation to calculate the benefit per the earnings definition as defined in the policy
2. Provide the Employee with the following documents in this package.
   - Group Life Insurance - Accidental Dismemberment Claim Statement – Employee
   - Group Life Insurance - Attending Physician Statement for Accidental Dismemberment
   - Authorization for the Use and/or Disclosure of Information
3. Please notify the Employee that we may require:
   - Copy of medical records, hospital records, police report and/or toxicology report
   - Authorization for Release of Claim Information
4. If an Accidental Death, one Beneficiary must complete/provide the following if available:
   - Group Life Insurance - Accidental Dismemberment Claim Statement – Employee
   - Copy of police report
   - Copy of autopsy report
   - Copy of toxicology report
   - If autopsy/toxicology are not being completed, please send verification of such from the coroner or medical examiner.
5. Return the documents to us by one of the following methods:
   - Email: claims.workforcebenefits@pacificlife.com
   - Mail: Pacific Life, Attn: Workforce Benefits - Claims, PO Box 2387, Omaha, NE 68103-2387
   - Fax: (949) 219-8872

Employee documents can be submitted separately upon completion

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Group Life Insurance - Accidental Dismemberment Claim Statement – Employer

Section 1: Information about the Employer

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

Section 2: Information about the Employee

Employee Name (First, MI, Last):	Date of Birth:	Social Security Number:	Date of Hire:	Effective Date of Employee Insurance:
Employee's Last Day Physically at Work (MM/DD/YYYY)	Employee's Premium Paid through date:	Employee Terminated? ○ Yes ○ No If Yes, date _____	Insurance Class:	Location:
Date of Last Pay Increase:	Employe pay included? ○ Hourly- Per hour $_____ ○ Salary – Annual salary $_____		Check applicable: ○ Commissions ○ Bonuses ○ Overtime	
Average Hours Worked per Week:	If claim is for a dependent, provide the following dependent information: Dependent Name: _____ Relationship to Employee_____ Date of Birth: _____ Dependent Social Security Number: _____			

Amount of Insurance being Claimed

Full amount of Employee's Basic AD&D: $_____ Full amount of Employee's Supplemental AD&D: $_____

Full amount of Dependent's Basic AD&D: $_____ Full Amounts of Dependent's Supplemental AD&D: $_____

Amount of Benefit being Claimed: Basic: $_____ Supplemental AD&D: $_____

Section 4: 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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Group Life Insurance - Accidental Dismemberment Claim Statement - Employee

Section 1: Information about the Employee/Retiree

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

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

Section 2: Information about the Injured Person

Last Name:	First Name:	Middle Name:
Date of Birth:	Date of Loss:	Social Security Number:
Relationship to Employee: ○ Self ○ Spouse ○ Domestic Partner ○ Civil Union Partner ○ Child		
Address: check here if the same as Employee: ☐	City and State:	ZIP:

Section 3: Information about the Accident

Date of Accident (MM/DD/YYYY)	Time of Accident: _____ AM _____ PM	Are you still working? ○ Yes ○ No If no, date stopped work? _____

Describe how the accident occurred and what caused it to happen:

Please describe the type of loss that you are claiming.

Is this a work-related injury/accident? ○ Yes ○ No

Have you modified your home to make it habitable after the injury? Or have you modified your vehicle to make it accessible after your injury?
○ Yes ○ No

If yes, please detail modifications.

Has the injury required rehabilitation physical therapy? ○ Yes ○ No

If yes, please detail.

Did any medical issue contribute to the accident? ○ Yes ○ No

If yes, please explain:

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Section 4: Information about Responding Authorities and Treatment Providers

Was an official investigative report completed (Fire Department, Police, OSHA)? ○ Yes ○ No

If yes, please include a copy of the report or provide contact information to obtain the report.

Case Number _____

Investigative Organization Name _____ Phone _____

Contact Address _____ City _____ ST_____ ZIP_____

Name _____ Phone _____

Contact Address _____ City _____ ST _____ ZIP_____

Were you treated by a physician(s) ○ Yes ○ No

Or hospitalized after the accident? ○ Yes ○ No

If yes, please indicate contact information.

Physician Name_____ Phone _____

Physician Address_____ City _____ ST _____ ZIP_____

Hospital Name_____ Phone _____

Hospital Address_____ City _____ ST _____ ZIP_____

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.
- 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 BACKUP 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 and supporting documentation 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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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)

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Claim 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.

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Group Life Insurance - Attending Physician Statement for Accidental Dismemberment

Section 1: Information about Patient

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

Section 2: Information about the Loss

Instructions: This claim forms serves the purpose of aiding us in reaching a decision regarding benefits. Please fill out all relevant sections and include copies of all supporting office notes, medical records, consultations, and test results. Don't forget to complete the signature section at the conclusion.

Date first consulted for injury/loss (MM/DD/YYYY):	Date of Accident (MM/DD/YYYY):	How often do you see this patient?

Diagnosis:

Injury resulted from?	Date of last treatment	Is injury work related?	Is this loss permanent and irrecoverable?
O Illness O Accident		O Yes O No	O Yes O No

If injury resulted from illness, please explain:

If injury resulted from an accident, please describe the accident:

What limitations does the patient have due to the injury?

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

Please detail 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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Please complete the following section(s) that apply to the loss in more detail.

Amputation information

What caused the limb/digit to be severed or amputated?

What limb/digit was severed or amputated?

Was limb/digit reattached? Results?

Date of amputation/severance (MM/DD/YYYY) _____

Indicate the exact point where the amputation/severance occurred:

Information about Loss of Vision

What caused the loss of vision?

Which eye was injured ○ Left ○ Right ○ Both

Has the patient suffered an entire and irrecoverable loss of sight following injury? ○ Yes ○ No

Current uncorrected vision	Current corrected Vision
O.D.v. _____	O.D.v. _____
O.S.v _____	O.S.v _____

Is any vision recovery expected? ○ Yes ○ No Comments:

Information about Loss of Hearing or Speech

What caused the loss of hearing:

Which ear was injured ○ Left ○ Right ○ Both

Has the patient suffered an entire and irrecoverable loss of hearing following an injury? ○ Yes ○ No

If no, expected date of recovery? (MM/DD/YYYY) _____

What caused the loss of speech:

Has the patient suffered an entire and irrecoverable loss of speech following an injury? ○ Yes ○ No

If no, expected date of recovery? (MM/DD/YYYY) _____

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Information about Paralysis

What caused the paralysis? Please describe the associated sensory and/or motor loss**:**

Type of paralysis: ○ Hemiplegia ○ Paraplegia ○ Quadriplegia ○ Triplegia ○ Uniplegia

Expected duration of the paralysis? ○ _____ Months ○ Permanent

Did injury result in a total paralysis of the limb(s)? ○ Yes ○ No

Information about Coma

What caused the coma?

Is/Was the patient in a state of complete and total unconsciousness with no response to external stimuli? ○ Yes ○ No

Any contributing factors to the cause of the coma?

What date did patient go into coma? (MM/DD/YY) _____

What date did patient come out of coma? ○ (MM/DD/YY) _____ or ○ Currently in coma

Information about Burns

What caused the burn?

What percentage of the skin surface was burned? _____% What degree was the burn? _____

Section 3: Signature of Attending Physician

The above statements are accurate and complete to the best of my knowledge and belief.

Physician Name:	Degree:	Specialty:
Address:	City:	State: ZIP:
Telephone:	Fax:	

Signature of Attending Physician _____ Date _____

Contact Person if any additional information needed:

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I have included the following:

○ Lab results ○ Office Notes ○ MRIs ○ Scans ○ EKGs ○ X-rays

Please return this completed form and records to one of the following:

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Fax: (949) 219-8872


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