PACIFIC LIFE

Life Claims

Beneficiary Claim Statements Package

This package of statements applies to life claims for natural or accidental deaths and applies to a Beneficiary or an Employee who experiences a spouse or dependent death. If the death is accidental, an additional statement is included:

- Group Life Insurance - Beneficiary Claim Statement Instructions
- Group Life Insurance - Beneficiary Claim Statement
- Group Life Insurance – Accidental Death Claim Statement
- Authorization for the Use and/or Disclosure of Information
- Authorization for Release of Claim Information (Optional)
- Employer/Group Policyholder Statement
- Claim Fraud Statements

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 - Beneficiary Claim Statement Instructions

Pacific Life is here to help you submit claims as timely as possible. If you have any questions regarding this statement or documentation required, please call us at 855-810-3301 from 8 a.m. through 8 p.m., Eastern Time.

Claim Submission Instructions:

1. Each beneficiary will need to complete this statement in its entirety. If the cause of death involved an accident, the Group Life Insurance - Accidental Death Claim Statement must also be completed by one beneficiary
2. Indicate if a Death Certificate, with cause and manner of death, is provided or has been provided by another party. A copy of the certificate is typically acceptable.
3. 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.
4. Review the Claims Fraud Statements and sign the completed statement where indicated.
5. Additional beneficiary documentation may be required with this statement:
   - If the beneficiary is the estate of the deceased, then a copy of the estate documents filed with the court naming an Executor or Administrator of the estate must be provided.
   - If the beneficiary is a minor child, then additional documentation will be required such as a Uniform Transfers to Minors Act (UTMA) affidavit or guardianship over the minor's financial estate.
   - If the beneficiary is a trust, then a copy of the trust documentation must be provided.
6. Return documents to us at by one of the following methods:
   - 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 – Beneficiary Claim Statement

Each Beneficiary must complete a separate Beneficiary Claim Statement.

A death certificate is ☐ included with this Beneficiary Claim Statement ☐ has been submitted by another party.

Section 1: Information about the Deceased

First Name:	Middle Name:	Last Name:
Address:	Maiden Name (if applicable):	Marital Status:
City:	State:	ZIP Code:
Date of Birth:	Date of Death:	Social Security Number:

Section 2: Information about you, the Beneficiary

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

First Name:	Middle Name:	Last Name:
Relationship to Deceased:	Maiden Name (if applicable):	Date of Birth:
Social Security Number:		
Address:	City: State:	ZIP Code:
Telephone Number:	Cell Phone Number:	Email:

Is there a funeral home assignment? ○ Yes ○ No If yes, please include the form provided by the funeral home.

If the Beneficiary is ☐ a minor child, ☐ estate, ☐ organization/charity, or ☐ trust, please provide contact name and contact information for the personal or legal representative. Please include guardianship documentation/trust or estate documents.

(Note: The information provided below along with any guardianship documentation/trust or estate documents may be used to issue and mail any benefit payment made in association with this claim.)

Contact Name:	Email:	Phone:
Address:	City: State:	ZIP Code:
Relationship:		

Section 3: Verification of Tax Status

Citizenship (check one) ○ U.S. Citizen ○ U.S. Resident ○ Non-Resident Alien (W-8BEN required)

Under penalties of perjury, I certify that each checked item below is true: ☐

- I am a U.S. citizen or U.S. resident alien;
- The Beneficiary's social security number/tax identification number listed above is correct;
- I am not subject to backup withholding due to failure to report interest or dividend income;
- I am not subject to FATCA reporting.

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Section 4: Beneficiary Signature

By signing, I attest that:

- The answers provided in this Beneficiary Claim statement are true and complete to the best of my knowledge.
- I have read and understand the information in the Claims Fraud Statements.
- 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:
Printed Name: First, MI, Last (include Title/Capacity, if applicable)	

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Group Life Insurance – Accidental Death Claim Statement

Only one statement per death is required

Section 1: Information about Employer and Employee:

Employer Name:	Policy Number:	Claim Number (if available):
Last Name of Employee:	First Name of Employee:	DOB (MM/DD/YYYY):

Section 2: Information about the Deceased

Last Name:	First Name:	Date of Birth (MM/DD/YYYY):
SSN:	Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Civil Union Partner ☐ Domestic Partner	Date of Death (MM/DD/YYYY):

Section 3: Information about the Accident

Date of Accident:	Time of Accident: _____ ☐ AM ☐ PM	Date of Death:	Cause of Death:

Where did the accident occur? Provide address, if applicable

Describe how the accident occurred:

What caused it to happen?

Did any medical issue contribute to the accident? ☐ Yes ☐ No If yes, please explain:

Was an Autopsy completed? ☐ Yes ☐ No Was a toxicology report completed? ☐ Yes ☐ No

If yes, please include a copy of the report(s) or provide contact information for the coroner/medical examiner.

Case Number _____ County _____

Contact Name _____ Phone _____

Contact Address _____ City _____ ST _____ ZIP _____

Was an official investigative report (accident/OSHA/police) completed? ☐ Yes ☐ No
If yes, please include a copy of the report or provide contact information to obtain the report.

Case Number_____

Investigative Organization Name _____

Contact Name _____ Phone _____

Contact Address _____ City _____ ST _____ ZIP _____

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Was the decedent treated by a physician(s) after the accident? ☐ Yes ☐ No
If yes, please provide contact information.

Physician 1 Name _____ Phone _____

Physician Address _____ City _____ ST _____ ZIP _____

Physician 2 Name _____ Phone _____

Physician Address _____ City _____ ST _____ ZIP _____

Was the decedent hospitalized after the accident? ☐ Yes ☐ No
If yes, please provide contact information.

Hospital Name _____ Phone _____

Hospital Address _____ City _____ ST _____ ZIP _____

Section 4: The Accidental Death policy may provide additional benefits for qualifying childcare reimbursement and/or higher education. Please indicate if a dependent is enrolled in childcare and/or higher education beyond 12th grade.

Dependent 1:

Last Name:	First Name:	DOB (MM/DD/YYYY):
Social Security Number:	Relationship to the Employee:	Phone:
Street:	City and State:	ZIP:

Dependent 2:

Last Name:	First Name:	DOB (MM/DD/YYYY):
Social Security Number:	Relationship to the Employee:	Phone:
Street:	City and State:	ZIP:

Dependent 3:

Last Name:	First Name:	DOB (MM/DD/YYYY):
Social Security Number:	Relationship to the Employee:	Phone:
Street:	City and State:	ZIP:

Dependent 4:

Last Name:	First Name:	DOB (MM/DD/YYYY):
Social Security Number:	Relationship to the Employee:	Phone:
Street:	City and State:	ZIP:

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Section 5. Beneficiary 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 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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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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Group Life Claim Statement – Employer/Group Policyholder Statement

Section 1: Employer/Group Policy Holder Information

Name:		Policy Number:	
Address:	City:	State:	ZIP:
Name of person completing the form:		Title of person completing the form:	
Telephone Number:		Email Address:	

Section 2: Employee/Retiree Information

Name (Last, First, MI):			Date of Birth (MM/DD/YYYY):	
Address:	City:		State:	ZIP:
Social Security Number:		Branch/Location:	Insurance Class:	Occupation:
Date of Hire:	Effective date of Employee Insurance:	Employee's last date physically at work:	Employee's Premium Paid through date:	Employee Terminated? ☐ Yes ☐ No If Yes, date _____
Date of last pay increase:		Employee pay included? Hourly – Per hour $_____ Salary – Annual salary $_____	Check applicable: ☐ Commissions ☐ Bonuses ☐ Overtime	
Hours worked per week:		If employee is no longer working, check applicable: ☐ Death ☐ Illness ☐ FMLA ☐ Resigned/Dismissed ☐ Retiree ☐ Other:		

Section 3: Employee /Retiree Decedent Information

Date of death (MM/DD/YYYY):

Amount of Insurance claimed for employee

Basic Life Insurance: $_____ Supplemental Life Insurance: $_____

If death is due to an Accident include below:

Accidental Death: $_____ Supplemental Accidental Death: $_____

Benefits are age reduced? ☐ Yes ☐ No

Did the employee designate a beneficiary for this coverage? ☐ Yes ☐ No

Please note that the most current Beneficiary Designation form must be submitted with claim in the case of an employee's death.

Have you obtained updated or additional information for the designated beneficiary(ies)? If so, provide below.

Name of Beneficiary 1:	Social Security Number:	DOB:
Contact information if available: phone:	Address:	
Email:	Relationship to decedent:	

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Name of Beneficiary 2:	Social Security Number:	DOB:
Contact information if available: phone:	Address:	
Email:	Relationship to decedent:	
Name of Beneficiary 3:	Social Security Number:	DOB:
Contact information if available: phone:	Address:	
Email:	Relationship to decedent:	
Attach separate sheet for additional beneficiaries.		

Section 4: Dependent Decedent Information

Relationship to Employee: ☐ Spouse ☐ Domestic Partner ☐ Child	Social Security Number:		
Address: Check here if it is same as employee	City:	State:	ZIP:
Was dependent child a full-time student: ☐ Yes ☐ No If college age, include enrollment verification of school. Was dependent disabled? ☐ Yes ☐ No If so, date of disability: _____	Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated		
Amount of Insurance being claimed: Basic Life: $ _____ Supplemental Life $ _____ Benefits are age reduced? ☐ Yes ☐ No	Dependent benefit amount is Flat amount _____ Percentage of Employee benefit amount _____ if based on Employee benefit amount, make sure to indicate employee benefit amount _____		

Section 6: Signature

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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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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