

Wellness

Claim Statement Package

This package is to be used by the primary insured to file a claim towards a Wellness Suite that may be included in Group Accident, Group Hospital Indemnity, and/or Group Critical Illness policies. Failure to complete this form and all parts may result in delay of processing the claim. The following forms are included:

Claim Fraud Statements

Wellness - Insured/Patient Statement

At Pacific Life, we are here to support you during the claims process. If you have any questions about this form or the required documentation, please reach out to us at (855) 810-3301 between 5 a.m. and 5 p.m., Pacific Time.

Additionally, you can consult your Certificate of Insurance and Schedule of Benefits for detailed information about your coverage. Keep in mind that there are specific rules — referred to as Limitations and Exclusions — that may apply during the claim evaluation. The information you provide in this claim package will be carefully reviewed to determine your eligibility for benefits.

Claim Submission Instructions:

1. Review the **Claim Fraud Statements** form for the state in which you reside and the state in which your policy was issued.
2. Complete, sign, and date the **Wellness Insured/Patient Statement**.
3. Return documents to us at:
 - 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

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.

Wellness – Insured/Patient Statement

Section 1: About the Primary Insured			
First Name:	Middle Initial:	Last Name:	Suffix:
Address:		City:	State: ZIP:
Date of Birth (mm/dd/yyyy):	Social Security Number:	Policy Number:	Preferred Phone Number:
Email Address:		When was your last day actively at work? (mm/dd/yyyy):	
Section 2: About the Patient <i>(If applying for self, you do not need to complete Section 2.)</i>			
First Name:	Middle Initial:	Last Name:	Suffix:
Date of Birth (mm/dd/yyyy):	Social Security Number:	Relationship to you? (check one) Spouse Domestic Partner Child	
Section 3: About the Wellness event			
Disclaimer: Refer to your Certificate of Insurance for details regarding specific benefits covered under the Wellness Suite as this may vary.			
Select one from the list below and provide the date it occurred.			
Behavioral Health	Genetic Testing	Routine Testing	
Blood Test	Mammography	Vaccination	
Family Caregiver	Personal Safety Course	Other	
Date of Screening/Visit (mm/dd/yyyy):			
Section 4: Information About the Physician and Treatment			
Complete this section to provide details related to the treating Physician for the Insured. <i>Attach a blank sheet with any additional provider details.</i>			
Physician Name:		Specialty:	
Address:		City:	State: ZIP:
Phone Number:		Fax Number:	

- 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 Claim 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.