Life, AD&D, Living/Accelerated Benefit Claim Form Instructions

Section A: **General Information –** to be completed by the employer's authorized representative.

Section B: **Circumstances of Death –** to be completed by the employer's authorized representative.

Section C: **Accident Information –** to be completed by the family's or the employer's authorized representative. If due to an accident, attach a copy of the accident report, medical examiners report or coroner's report.

Section D: **Beneficiary Information –** to be completed by the family's or the employer's authorized representative. For additional space, attach a separate sheet.

Section E: **Attending Physicians Statement** – to be completed by the employee's attending physician(s). Please complete this section if the employee is applying for Living/Accelerated Benefits.

Section F: **Release of Information –** to be completed by the family's authorized representative.

Life Insurance Claim Requirements

- Completed claim form.
- Certified copy of the Death Certificate.
- Copy of the individual's application (for beneficiary verification).
- Copy of the previous year's W-2 form.
- If due to an injury or accident (MVA, suicide, etc.):
    - Copy of the police report.
    - Copy of the autopsy report, including toxicology results.
    - Any newspaper articles or obituary.
- Medical records may be requested if the death occurred within two years of the effective date.

Questions/Assistance

For questions or assistance, please contact EPIC's Claims Department at 800-520-5750 or claims@epiclife.com.

Submitting Your Claim

Please ensure all three sections of your claim form are fully completed, signed and dated. Please mail your claim form and any supporting documentation to:

The EPIC Life Insurance Company
Attention: Life & Disability Claims
P.O. Box 8430
Madison, WI 53708-8430

EPIC LIFE INSURANCE

Life, AD&D, Living/Accelerated Benefit Claim Form

☐ **Life Claim (Parts A-D, F)** ☐ **AD&D Claim (Parts A-D, F)**

☐ **Supplemental Life Claim (Parts A-D, F)** ☐ **Living/Accelerated Benefit Claim (Parts A, E, F)**

A. Employer Completes — General Information

Name of Insured Group	Street Address of Insured Group		
Telephone	City	State	Zip

Policy Number	Certificate Number	Effective Date of Insurance	Date Premium Paid for Insured	Amount of Insurance

Full Name of Insured Employee	Address of Insured Employee	Annual Salary of Employee	Employee Social Security No.

Full Name of Deceased/Patient	Address of Deceased/Patient	Relationship to Employee	Deceased/Patient on Premium Waiver?

B. Employer Completes — Circumstances of Death

Date of Death	Place (if hospital or institution, provide name and address)	Date Sickness Commenced	Date physician first consulted for last sickness

Was deceased considered an active eligible employee/dependent at time of death? ☐ Yes ☐ No

Date Employee Last Worked (for both employee and dependent claims)	Reason for Stopping Work

Date Completed	Printed Name of Person Completing this Form	Signature of Employer's Authorized Representative	Title (officer of the company)

C. Family Completes — Accident Information

If due to accident, attach a copy of the accident report, medical examiners report or coroner's report.

Date of Accident	Was accident on the job or arise out of, or in the course of, deceased's employment? ☐ Yes ☐ No

Describe how, where, and when fatal injury occurred and nature of injuries sustained.

D. Family Completes Beneficiary Information

For additional space, attach separate sheet.

Name of Beneficiary	Social Security Number	Relationship	Date of Birth	Telephone Number

Street Address	City	State	Zip

Name of Beneficiary	Social Security Number	Relationship	Date of Birth	Telephone Number

Street Address	City	State	Zip

E. Attending Physicians Statement

Name of Patient	Date of Birth

When did symptoms first appear or accident happen?	Date you advised your patient to stop working	Has patient ever had same or similar condition?

Is condition due to injury or sickness arising out of patient's employment?	Name and addresses of other treating physicians.

Diagnosis (including complications)	Subjective Symptoms

Objective Findings (including current x-rays, EKG's, laboratory data and any clinical findings)

Date of First Visit	Date of Last Visit	Frequency ☐ Weekly ☐ Monthly ☐ Other (specify)

Nature of Treatment (including surgery and medications prescribed, if any)

Has Patient:	Is Patient:
☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed	☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined ☐ Hospice care

Has patient been hospital confined? If yes, provide name and address of hospital.

Confined from _____ through _____

Please indicate patient's long-term and short-term prognosis (including life expectancy).	Indicate duration of illness (from initial onset to present).

Print Attending Physician Name	Medical Specialty	Telephone

Street Address	City	State	Zip

Signature	Date

F. Family Completes — Release of Information

AUTHORIZATION TO DISCLOSE HEALTH-RELATED INFORMATION
(This Authorization complies with the HIPAA Privacy Rule)

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility or provider, clearinghouse, health plan, insurance or reinsuring company, agent, broker, service provider, credit bureau or other consumer reporting agency, employer, the Veterans Administration, the Medical Information Bureau, Inc., or any other personal or business associate to disclose any and all "Information" about me to The EPIC Life Insurance Company, its employees, agents or representatives ("EPIC Life"). "Information" may include my entire medical record (including records created after the date of my signature), diagnosis, prognosis, prescription history, medicines prescribed, treatment or care of any physical or mental condition concerning me, including information about HIV/AIDS, drug or alcohol abuse or mental illness (excluding psychotherapy notes), and/or financial, consumer report, or any other medical or non-medical information about me.

The Information to be disclosed under this Authorization may be used by EPIC Life to: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities relating to any coverage I have or have applied for with EPIC Life.

I understand that I have the right to revoke this Authorization at any time by providing written notice of revocation to EPIC Life. I am aware that my revocation will not be effective until received by EPIC Life and will not be effective regarding the uses and/or disclosures of my Information that EPIC Life has made prior to receipt of my revocation. If the authorization was obtained as a condition of obtaining insurance coverage, other law provides EPIC Life with the right to contest a claim under the policy or the policy itself. A copy of this form shall be as valid as the original.

I understand that I am under no obligation to sign this Authorization but that my refusal to sign it may prevent EPIC Life from being able to process my application for coverage, determine my eligibility or make benefit payments. My physician or other health care provider may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that once Information is disclosed under this Authorization, it may no longer be protected by federal privacy rules and may be re-disclosed by the person or entity that receives it. I am entitled to keep a copy of this form for my records. This Authorization shall expire 30 months from the date signed.

I certify that the information I have provided on this form is true, complete, and accurate to the best of my knowledge and belief. I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss may be subject to imprisonment, fines, denial of insurance, and/or civil damages.

Name of Claimant	Claimant's Date of Birth
Signature of Claimant or Personal Representative*	Date Signed
Telephone Number	

*Personal Representative's Authority or Relationship to Claimant (attach any supporting documentation)

MAIL OR FAX FORM TO:

The EPIC Life Insurance Company
Attention: Life & Disability Claims
P.O. Box 8430
Madison, WI 53708-8430
claims@epiclife.com
Fax: 608-223-2159 or 800-236-7610

For Life Benefits – A CERTIFIED COPY OF THE DEATH CERTIFICATE MUST ACCOMPANY THIS FORM

For residents of Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Mississippi, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, Wisconsin, West Virginia: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** EPIC shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

For residents of 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 a person to criminal and civil penalties.