AGENT USE ONLY C14 ☐

Life Insurance Claim Form

BANKERS CONSECO LIFE INSURANCE COMPANY
Home Office-Jericho, New York
Life Claims Department–P.O. Box 1937
Carmel, Indiana 46082-1937
(800) 845-5512

FIRST MI LAST

DECEDENT

POLICY NUMBER DATE OF DEATH

A DECEDENT AND POLICY INFORMATION

SOCIAL SECURITY NUMBER DATE OF BIRTH

OTHER KNOWN NAMES OF DECEDENT

CAUSE OF DEATH

PLACE OF DEATH

☐ Proceeds have been assigned. (*Provide assignment documentation with Claim Form.)*

B CLAIMANT INFORMATION

NOTE: PROVIDE ADDENDUM OR SUBMIT ADDITIONAL CLAIM FORM IF MULTIPLE CLAIMANTS.

FIRST NAME MI LAST NAME

BUSINESS OR ENTITY NAME

ADDRESS 1

ADDRESS 2

CITY STATE ZIP

EMAIL

PHONE ALTERNATE PHONE

SOCIAL SECURITY NUMBER **OR** EMPLOYER IDENTIFICATION NUMBER

DATE OF BIRTH

RELATIONSHIP TO DECEDENT

C. PAYMENT OPTIONS

SELECT **ONE** DISBURSEMENT METHOD:

☐ Single Check Payment

☐ Proceeds on Deposit

☐ Other _____

Refer to policy or contact us at the number provided for other payment options.

D TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

☐ **Under penalties of perjury**, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

3. I am a U.S. citizen or other U.S. person (that is, an individual who is a **U.S. citizen** or **U.S. resident alien**, a partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, an estate [other than a foreign estate], or a domestic trust [as defined in Regulations section 301.7701-7]).

Certification instructions: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.Your signature at the bottom of this form certifies that you have read and attest to the information provided.

E. THE FOLLOWING DOCUMENTS ARE ATTACHED

☐ Certified Death Certificate

☐ Original Policy

☐ Assignment Documents

☐ Medical Authorization Form

☐ Accidental Death information (Section G)

☐ Medical History Information (Section H)

☐ Other _____

F. CLAIMANT STATEMENT AND SIGNATURE

☐ **Certificate of Lost Policy:** I certify that the life insurance policy identified has been lost or destroyed and, to the best of my knowledge, is not in anyone's possession. If the original should be found or come into my possession, I will return it to the Company, its successors or assignees. It is understood and agreed that the original policy shall become null and void.

I, the claimant, hereby make claim to the proceeds payable under the provisions of this policy and agree that all papers called for by the Company shall be part of this statement. My signature below also certifies, separately, that the information in Sections A - H is true and correct to the best of my information and belief, subject to penalties for perjury.

BENEFICIARY SIGNATURE _____ DATE _____

See IMPORTANT INFORMATION insert for additional information and instruction

G. ACCIDENTAL DEATH INFORMATION

PROVIDE THE FOLLOWING INFORMATION IF THE DEATH WAS ACCIDENTAL:

DATE OF ACCIDENT

LOCATION OF ACCIDENT

DESCRIPTION OF ACCIDENT

H. MEDICAL HISTORY INFORMATION

COMPLETE THE ENCLOSED MEDICAL AUTHORIZATION FORM AND SUBMIT WITH THE CLAIM.

PROVIDE THE FOLLOWING INFORMATION IF THE POLICY HAS BEEN ACTIVE FOR LESS THAN TWO (2) YEARS:

DATE DECEDENT FIRST COMPLAINED OR GAVE OTHER INDICATION OF FATAL ILLNESS

DATE DECEDENT FIRST CONSULTED A PHYSICIAN FOR THE FATAL ILLNESS

Name and address of the decedent's Primary Care Provider:

FIRST NAME LAST NAME SUFFIX

BUSINESS OR ENTITY NAME

ADDRESS 1

ADDRESS 2

CITY STATE ZIP

Provide the names and addresses of all other health care providers that treated the decedent during the past 2 years:
NOTE: PROVIDE ADDENDUM FOR ADDITIONAL HEALTH CARE PROVIDERS

FIRST NAME LAST NAME SUFFIX

BUSINESS OR ENTITY NAME

ADDRESS 1

ADDRESS 2

CITY STATE ZIP

DATE TREATED DISEASE OR CONDITION

Provide the names and addresses of all other health care providers that treated the decedent during the past 2 years:
NOTE: PROVIDE ADDENDUM FOR ADDITIONAL HEALTH CARE PROVIDERS

FIRST NAME | LAST NAME | SUFFIX

BUSINESS OR ENTITY NAME

ADDRESS 1

ADDRESS 2

CITY | STATE | ZIP

DATE TREATED | DISEASE OR CONDITION

FIRST NAME | LAST NAME | SUFFIX

BUSINESS OR ENTITY NAME

ADDRESS 1

ADDRESS 2

CITY | STATE | ZIP

DATE TREATED | DISEASE OR CONDITION

FIRST NAME | LAST NAME | SUFFIX

BUSINESS OR ENTITY NAME

ADDRESS 1

ADDRESS 2

CITY | STATE | ZIP

DATE TREATED | DISEASE OR CONDITION

Important Information

Life Insurance Claim Form

MAILING ADDRESS

Bankers Conseco Life Insurance Company
Home Office - Jericho New York
Life Claims Department – PO Box 1937
Carmel, IN 46082-1937
(800) 845-5512
www.Bankers.com

DEFINITIONS

- **Owner:** The person who applies for and purchases the policy.
- **Insured:** The person whose life is insured under the policy.
- **Primary Beneficiary:** The person or entity designated to receive benefits upon the death of the insured.
- **Contingent Beneficiary:** The person or entity that is designated to receive benefits in the event the designated primary beneficiary is no longer living at the time of the insured's death.
- **Assignee:** The entity such as a funeral home or cemetery that is assigned to receive part or all of the death proceeds upon the death of the insured.

INSTRUCTIONS

- Complete all sections of the Claim Form.
- Sign and date the Claim Form.
- Mail to address listed above.

DECEDENT AND POLICY INFORMATION

- Provide all information in Section A of the Claim Form.
- In certain circumstances a routine investigation may be necessary. You will be notified if an investigation is initiated.
- Indicate in Section A of Claim Form if there is an assignment of proceeds by checking the Assignment of Proceeds box. An assignment on the Assignee's company letterhead, signed by all beneficiaries and an officer of the company must be submitted with the Claim Form along with an itemized billing statement.

CLAIMANT INFORMATION

- Complete all information in Section B of the Claim Form.
- If there is more than one Claimant on the claim, a separate Claim Form or addendum must be submitted.

PAYMENT OPTIONS

- Select one method for disbursement of policy benefits in Section C of the Claim Form. Supply all requested information for the method selected. Once benefit disbursement has been made other disbursement options are no longer preserved.
- These payment options may be available based on the policy:
  - **Single Check Payment:** Provides immediate payout with a single check issued for the total amount of the payment.
  - **Proceeds on Deposit**: The benefit may be left on deposit with us to accumulate interest for an agreed upon period of time.
  - **Other Options**: Some policies may have other payment options available. Refer to your policy or contact us at the number provided for additional payment options. Indicate the other payment option desired under OTHER in Section C of the Claim Form.

Important Information

Life Insurance Claim Form

TAX ID NUMBER AND CERTIFICATION

- Submit IRS form W-9 or complete the certification in Section D of the Claim Form.
- All beneficiaries must provide their Social Security Number, Employer, Trust or Estate Tax Identification Number and complete the certification ensuring this number is correct AND indicating if you are subject to Backup Tax Withholding. If this section is not completed, the interest earned may be subject to Federal or State withholding.
- Indicate on the "other" line in Section E of the Claim Form if a W-9 form is being submitted with the claim.

REQUIRED DOCUMENTATION

- Identify the documents that are being submitted with the Claim Form in Section E of the form.
- The following items should be submitted with the Claim Form if applicable:
  - **Assignment:** An assignment on the Assignee's company letterhead, signed by all beneficiaries and an officer of the company must be submitted with the Claim Form along with an itemized billing statement.
  - **Certified Death Certificate:** The Certified Death Certificate is needed to process the Life Insurance Claim. A Certified Death Certificate has the seal of the validating authority. Photocopies are not valid.
    - If any beneficiary is deceased a copy of his or her death certificate must also be included.
  - **Children of Insured**: If the beneficiaries are the children of the insured and have not been designated by name, a notarized list of the children is required. Their current mailing addresses, telephone numbers, dates of birth and Social Security numbers are also required.
  - **Corporation**: If the beneficiary is a corporation, an authorized officer of the corporation must sign the Claim Form. The officer's title must follow the signature. A Corporate Resolution or other supporting documentation is required for each officer's signature.
  - **Divorce Decree**: A Divorce Decree may be requested during the claim review process if the deceased was divorced.
  - **Estate Beneficiary:** If an estate will not be opened, the Claimant is responsible for contacting an attorney or the local probate court clerk in the proper jurisdiction for an affidavit of small estate or heirship.
  - **Original Policy:** Return all pages of the original policy with the Claim Form.
  - **Power of Attorney:** A copy of the Power of Attorney is required if an attorney-in-fact is filing on behalf of a designated beneficiary.
  - **Minor Child Beneficiary:** If the beneficiary is a minor child, the Certified Guardianship paperwork must be submitted with the Claim Form.
    - If guardianship documents cannot be obtained, the company will work with the minor's parents or legal guardian and their counsel to determine an alternative method of payment. Payment may be possible under the state's Uniform Transfers to Minors Act.
  - **Trust Beneficiary:** If the beneficiary is a trust, a copy of the Trust and any Amendments should be submitted with the claim.

ACCIDENTAL DEATH INFORMATION

- The following items should be completed if the death was accidental:
  - Section G of the Claim Form: ACCIDENTAL DEATH INFORMATION.
  - Medical Authorization Form. The Medical Authorization Form provides your consent to review medical files during the claim review process.
- Indicate in Section E of the Claim Form that the information is being submitted with the claim.

MEDICAL HISTORY INFORMATION

- The following items should be completed if the policy has been active for less than two (2) years:
  - Section H of the Claim Form: MEDICAL HISTORY INFORMATION.
  - Medical Authorization Form. The Medical Authorization Form provides your consent to review medical files during the claim review process.

FRAUD WARNING NOTICES
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NOTICE: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

ALASKA, DELAWARE, FLORIDA, IDAHO, NEW YORK: Your state requires us to notify you that: any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony as further defined by your state statute.

ARKANSAS, HAWAII, LOUISIANA, MAINE, NEW MEXICO, RHODE ISLAND, TENNESSEE, TEXAS, VIRGINIA, WEST VIRGINIA: 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 fines and confinement in prison.

ARIZONA, KENTUCKY, OHIO: WARNING: any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

CALIFORNIA: For your protection California law requires the following warning statement to appear on this form: Any person who knowingly presents a 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.

COLORADO: WARNING: any person who knowingly and with intent to defraud an insurer provides false, incomplete or misleading information is subject to criminal and civil penalties, including imprisonment, fines and denial of insurance. Any agent who knowingly and with intent to defraud a policyholder or claimant provides false, incomplete or misleading information with regard to a settlement or insurance proceeds payable will be reported to the Colorado Insurance Department.

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.

INDIANA, MINNESOTA: Your state requires us to notify you that: any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 HAMPSHIRE: Your state requires us to notify you that any person, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud under New Hampshire law.

NEW JERSEY, PENNSYLVANIA: NOTICE: 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.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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 include imprisonment, fines and denial of insurance benefits.

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Authorization to Obtain Medical Records

For Life Insurance - Pursuant to the HIPAA Privacy Rule

1. Insured party whose medical records will be obtained

Printed Name	Date of Birth	Social Security Number

Address	City	State	Zip Code

2. Disclosing Party

Any physician or other health care provider, hospital, clinic, medical facility, clinical lab, pharmacy, pharmacy benefit manager or pharmacy-related organization, insurance company or health plan, Social Security Administration, or the insured party's employer

3. Description of information authorized for release

Any information related to past, present or future health condition(s), medical care or treatment, which includes information about mental health, communicable disease, HIV/AIDS and substance abuse, but excludes psychotherapy notes

4. Purpose of this Authorization

To administer benefits under a policy or certificate of insurance

5. Duration of Authorization

Twenty-four (24) months from the date written below, unless I specify an earlier date here: _____

6. Receiving Party

CNO Services, LLC on behalf of one or more of the following insurance affiliates: Bankers Life and Casualty Company, Bankers Conseco Life Insurance Company *, Colonial Penn Life Insurance Company, Conseco Life Insurance Company, Washington National Insurance Company

*domiciled in and licensed in the State of New York

Page 2 - Authorization to Obtain Medical Records

For Life Insurance - Pursuant to the HIPAA Privacy Rule

7. Review carefully before signing

- Refusing to sign this Authorization does not affect the terms of the insured party's coverage, but may prevent a determination of whether life insurance benefits are payable.
- This Authorization must be signed by the insured party or his/her Legal Representative if the insured party is incapacitated or deceased (i,e., Executor or Next-of-Kin). Documentation of the Legal Representative's authority must accompany this Authorization (i.e. Estate Paperwork, Marriage License, Affidavit of Next-of-Kin).
- This Authorization may be revoked at any time, except to the extent it has been relied upon by sending a written revocation to Customer Service 11825 N. Pennsylvania Street, Carmel, IN 46032.
- If the party authorized to receive information described in this Authorization is not subject to federal health information privacy laws then such information could be re-disclosed and would no longer be protected by these laws.
- The insured party/Legal Representative has a right to receive a copy of this Authorization and a photocopy or facsimile shall be as valid as the original.
- Return a signed and dated Authorization in the enclosed envelope.
- **IMPORTANT** - This Authorization is not valid if not signed and dated, or if both pages are not enclosed.

8. Signed and dated by the insured party or Legal Representative*

Printed Name	Relationship
Signature	Date

***Legal Representatives must enclose documentation of legal authority**

Customer Service
11825 N. Pennsylvania Street - Carmel, IN 46032