Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company
P.O. Box 8043 Little Rock AR 72203-8043
Claims fax: 866-224-6547
Claims email: TEBclaimsscanning@transamerica.com
Claims customer service: 800-251-7254

Instructions for Submitting a Death Claim Form

Claims Customer Service: 800-251-7254 (7:00 a.m. – 6:00 p.m. Monday-Thursday and 7:00 a.m. – 5:00 p.m. Friday)

The package has four parts: Claimant's Statement, Employer's/Business Entity's Statement, Required Fraud Warning Statements and Authorization for the Release of Health Information.

CLAIMANT'S STATEMENT (page 1 of the death claim form):

General instructions

1) The beneficiary completes the Claimant's Statement. If there is more than one claimant, each should complete a claimant's statement. If you need additional forms, you may make and use photocopies of the original.
2) Please provide all of the information requested or write NA (for not applicable) on lines you intend to leave blank. If you need additional space for any answer you may add additional pages.
3) Please know that you pay costs for the claim, including fees for death certificates or legal documents that may be needed.
4) If the policy has been in force for less than two years, or was reinstated in the past two years, we will send you a medical provider list and authorization form to complete.

Assignments

5) You may have signed a form that authorizes us to pay some or all of your benefit to a Funeral Home or for other final expenses. If so, please send a copy of the assignment and the itemized statement with your claim.
6) Each beneficiary who is sharing the expense(s) must sign the assignment.
7) The owner of the policy may have made a collateral assignment. A collateral assignment means some or all of the policy benefit was assigned to someone other than the beneficiary/ies. The assignee must complete a claimant's statement.

Minor beneficiaries, estates and trusts

8) The interests of minors and other beneficiaries who are not legally competent are protected. We will follow state laws regarding how we can pay these benefits. Please know that you may need to get court orders or send legal documents to us in order to issue payment. If a guardian was appointed by a court, the guardian completes the claimant's statement and sends a copy of the court order. If additional steps are needed, we will provide you further instructions once we review the claim.
9) If the beneficiary is the insured's estate, the person named Executor or Administrator of the estate completes the claimant's statement. Send a copy of the court order that names the executor or administrator.
10) If the beneficiary is a trust, the Trustee completes the claimant's statement and sends a copy of the trust or trust certificate.

Tax withholding

11) Under federal tax laws, each claimant is required to provide their Social Security or tax reporting number and certify whether he or she is subject to backup withholding. You may be subject to backup withholding if (1) you fail to provide us with your Social Security or tax reporting number, pursuant to Internal Revenue Code ("IRC") Section 3406(a)(1)(A); or (2) you were notified that you have underreported interest or dividend income or you were required to but failed to file a return which would have included reportable interest or dividend income, pursuant to IRC Section 3406(a)(1)(C). If you are subject to these backup withholding rules, we are required to withhold 28% of any reportable interest payments. **Indicate whether you are subject to backup withholding on claim form question #6.**

EMPLOYER'S/BUSINESS ENTITY STATEMENT (page 2 of the death claim form):

12) Please know that this statement is needed for universal life insurance if it has been less than two years since the insured applied for the policy of if the policy lapsed and was reinstated in the last two years. It is always needed for group term life insurance.
13) An authorized representative of the employer/business entity completes this statement. The representative is usually a company officer or someone in human resources.
14) If the group is self-administered, the employer/business entity also sends proof that premium deductions were made for the policy and the amount paid.
15) Send a copy of the enrollment form with the completed employer/business entity statement.
16) NOTE: If the deceased insured was a dependent or was not the policy owner, and premiums were paid by salary deduction, the policy owner must ask the employer/business entity to stop deducting premiums for the insured's policy or policy rider.

CERTIFIED DEATH CERTIFICATE

17) Please know that we need an original death certificate, or a certified copy, that includes the manner of death. If the insured was a victim of homicide or died as the result of an accident, we will also need copies of the police or accident report.

REQUIRED FRAUD WARNING STATEMENTS

18) Please locate the warning for your state of residence and sign the acknowledgement.

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

19) Please complete and sign the authorization. Although we do not obtain health information for every claim, completing this form will minimize the chance of delay in the event it is needed. Please know that some medical facilities will require you to complete additional forms.

SPECIAL NOTE:

<u>Your claim may require extra time to process if:</u>

The claim forms are incomplete

- The claim in incurred less than 2 years after the insurance application was signed or if the policy lapsed and was reinstated within 2 years of the date of death. Please know that we will ask you for a medical provider list and will obtain medical records.
- The insured did not name a beneficiary or if no beneficiary survived the insured.
- The beneficiary is a minor, a legally incapacitated person, a trust, or if benefits are payable to the estate of the insured or estate of the policy owner.
- The insured died outside the United States.
- The insured was a victim of homicide.

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Death Claim Form

Decedent's Information				
1. Name in Full	2. Social Security No.	3. Policy No. BL00057281		
4. Date of Birth	5. Street Address	6. City	7. State	8. Zip Code
9. Employer's Name				
10. Street Address	11. City	12. State	13. Zip Code	
14. Date Last Worked	15. Occupation at Death			
16. Date of Death	17. Place of Death	18. Cause of Death		

Claimant's Information		
1. Name in Full	2. Social Security No.	3. Date of Birth
4. Daytime Phone Number	5. Evening Phone Number	
6. Email address:		

7. Are you subject to backup withholding? ☐ Yes ☐ No *(see instruction # 11 for more information on taxes)*
I certify that this is my correct tax reporting number, and that I am not subject to backup withholding.

Signature _____ Date _____

This claimant made claim to the insurance and agrees that by furnishing this form, the Company does not affirm that any insurance was in force on the life of the deceased and does not waive any of its rights or defenses.

Signed in (City/State) _____ This _____ Day of (Month/Year) _____ .

_____ Relationship to deceased
Signature

Mailing Address	City	State	Zip code
Street Address	City	State	Zip Code

The information above is true and correct to the best of my knowledge.

Claimant's Signature _____ Date _____

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Employer's/Business Entity's Statement

1. Decedent's Name in Full	2. Decedent's Age	3. Employee's/Insured Person's Name	4. Employee's/Insured Person's Social Security No.

5. Name of Company	6. Group Policy No.	7. Employee/Insured Person was ☐ Salaried ☐ Hourly	8. Employee's/ Insured Person's annual salary as of the date of loss

9. Date Insured (employee/insured person)	10. Date Insured (dependent)	11. Date of Hire	12. Last date Employee/Insured person actively worked

13. Employee's/Insured Person's status as of last date worked: ☐ Active ☐ Vacation ☐ Leave of Absence ☐ Laid Off ☐ Terminated ☐ Retired If other than Active, Please explain:_____	14. Date employee/insured person returned to work:

15. Did injury occur while at work? ☐ Yes ☐ No	16. If "Yes", give date of injury and details

17. Amount of Insurance	18. Amount of Claim	19. Was premium paid and insurance in force at time of loss? ☐ Yes ☐ No

Signed in (City/State) _____ This _____ Day of (Month/Year) _____ .

Printed Name of Authorized Representative	Signature of Authorized Representative	Official Title

Phone Number _____ Fax Number _____

REQUIRED FRAUD WARNING STATEMENTS

Claimants are required to acknowledge receipt of fraud warnings. Please refer to the fraud warning statement for your state as indicated below. Sign, date, and return with claim documents.

FOR RESIDENTS OF **ALASKA**: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Claimant's signature Date

FOR RESIDENTS OF **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.

Claimant's signature Date

FOR RESIDENTS OF **CALIFORNIA**: For your protection California law requires the following 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.

Claimant's signature Date

FOR RESIDENTS OF **COLORADO**: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from the insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Claimant's signature Date

FOR RESIDENTS OF **DELAWARE**, **IDAHO**, **INDIANA** or **OKLAHOMA**: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Claimant's signature Date

FOR RESIDENTS OF **DISTRICT OF COLUMBIA** or **LOUISIANA**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Claimant's signature Date

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 any false, incomplete, or misleading information is guilty of a felony of the third degree.

Claimant's signature Date

FOR RESIDENTS OF **MAINE**, **TENNESSEE** or **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.

Claimant's signature Date

FOR RESIDENTS OF **MARYLAND**, **RHODE ISLAND**, **TEXAS** or **WEST VIRGINIA**: 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.

Claimant's signature Date

FOR RESIDENTS OF **MINNESOTA**: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Claimant's signature Date

FOR RESIDENTS OF **NEW HAMPSHIRE**: Any person who, 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, as provided by RSA 638:20.

Claimant's signature Date

FOR RESIDENTS OF **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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Claimant's signature Date

FOR RESIDENTS OF **NEW JERSEY**: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Claimant's signature Date

FOR RESIDENTS OF **OHIO**: 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.

Claimant's signature Date

FOR RESIDENTS OF **OREGON**: Any person who knowingly and with intent to defraud an insurance company files an application for insurance or statement of claim containing any materially false information may be guilty of insurance fraud. To deny a claim on the basis of misstatements, misrepresentations, omissions or concealments, the misinformation must be material to the content of the policy, the insurer relied upon the misinformation and the information was either material to the risk assumed by the insurer or provided fraudulently. Misstatements, misrepresentations, omissions or concealments are not fraudulent unless they are made with the intent to knowingly defraud.

Claimant's signature Date

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 such a person to criminal and civil penalties.

Claimant's signature Date

FOR RESIDENTS OF **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 $5,000 and not more than $10,000, or a fixed term of imprisonment for 3 years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of 5 years, if extenuating circumstances are present, it may be reduced to a minimum of 2 years.

Claimant's signature Date

FOR RESIDENTS OF **VIRGINIA**: Any person who, with the 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 may have violated the state law.

Claimant's signature Date

FOR RESIDENTS OF **ALL OTHER STATES AND TERRITORIES**: Any person who knowingly, and with intent to injure, defraud or deceive 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.

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AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of health information about the Insured as described below and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any physician, medical practitioner, hospital, clinic, pharmacy, long-term care facility, nursing home, assisted living facility, home health care entity, medical or medically-related facility, laboratory, and insurance company (including the Company selected above), or other organization, institution or person having records or knowledge of the Insured's health.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** the Company noted above, its affiliates, its reinsurers, their agents or other representatives, and business associates.
3. **Description of the information that may be used or disclosed:** This authorization relates to the release of any medical records necessary to evaluate and determine the Insured's eligibility for benefits, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse information, or information regarding AIDS. **Exception: psychotherapy notes require a separate signed authorization.**
4. **The information will be used or disclosed only for the following purpose(s):** The requested information will be used for any claim processing purposes, including but not limited to determining the Insured's benefit eligibility and making benefit determinations.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that the Insured's eligibility for benefits may be affected if I refuse to sign this form. In that case, the Company may not be able to determine if the Insured qualifies for benefits.
- I understand that the Insured has a right to receive the HIPAA Notice of Health Information Privacy Practices that explains the Company's privacy practices (not applicable to life, accident or disability insurance policies).
- I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment or health care operations.
- This authorization shall be valid for as long as claims continue under the policy, and I understand I am entitled to a signed copy.
- A copy of this authorization will be considered as valid as the original.
- I acknowledge that I have received a copy of this authorization.

Patient/Insured's Name/Signature _____ Date _____

Patient/Insured's SSN _____ Patient/Insured's Date of Birth _____ Patient/Insured's Phone No. _____

Patient/Insured's Address _____

Personal Representative's (if any) Name/Signature: _____ Personal Representative's Phone No. _____

Personal Representative's (if any) Address _____

Description of Personal Representative's Authority or Relationship to Patient/Insured _____

Policy or Contract Number _____

Claimant should retain a copy of this signed document for their records