BEST Life™
BEST Life and Health Insurance Company

P.O Box 890, Meridian, ID 83680-0890
(800) 433-0088 • (208) 893-5040 fax
www.bestlife.com

Proof of Accidental Injury, Dismembermet Policyholder's Statement

STATEMENT OF POLICYHOLDER

This claim is being made for: ☐ Employee ☐ Spouse of Employee ☐ Dependent Child of Employee ☐ Other

Name of Claimant	Phone Number	Claimant's Date of Birth	Claimant's SSN#
Claimant's Address	**Group Policy No.**	**Certificate No.**	**Amount of Life Insurance**
Name and Address of Employee	**Phone Number**	**Employee's Date of Birth**	**Employee's SSN#**
Name and Address of Employer	**Phone Number**	**Type of Employment**	
		☐ Union ☐ Non-Union ☐ Full Time ☐ Part Time	

Employee's Job Title	Hours Worked Per Week	Weekly Earnings	Duration of Employment	Disability Benefits were Paid
			From Through	From To

Date of premium payments	Last day of full time active work	Insurance Class	Reason for stopping work
From To			☐ Illness ☐ Leave of Absence ☐ Retirement ☐ Lay Off ☐ Other:

Carrier's Name and Address	If Contributory Insurance, to what date has contributions been paid?
	From To

Send correspondence and check to

Signature of Policyholder's Official Representative ***X*** Date

Print Name of Signature Above Telephone Number

THE ORIGINAL ENROLLMENT CARD OR APPLICATION FOR INSURANCE SHOULD ACCOMPANY THIS FORM, IF MAINTAINED BY THE POLICYHOLDER.

BY FURNISHING THIS BLANK INVESTIGATING CLAIM, THE COMPANY SHALL NOT BE HELD TO ADMIT THE VALIDITY OF ANY CLAIM OR TO WAIVE THE BREACH OF ANY CONDITION OF THE POLICY.

FRAUD WARNING: AS REQUIRED BY LAW, 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 ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH MAY BE CONSIDERED CRIME.

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Proof of Accidental Injury, Dismembermet
Attending Physician's Statement

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ATTENDING PHYSICIAN'S STATEMENT

Complete for all claims: Attach copies of medical records and all operative reports for the claimed injury and loss.

Name of Patient	Date of Accident

Date you last treated for this accident	Is patient under care for any other illness or medical disorder?
	☐ Yes ☐ No ☐ Unknown If yes, list diagnosis:

Did the underlying medical disorder contribute to the loss?	Are you the patient's regular physician?
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No If no, physician's name and address:

Briefly describe accident	Diagnosis and description of injuries

Was patient hospitalized?	Hospital Name and Address
☐ Yes ☐ No If yes, Admission Date: Discharge Date:	

COMPLETE FOR DISMEMBERMENT ONLY

Loss: ☐ Right Arm ☐ Left Arm at:
☐ Elbow ☐ Shoulder
☐ Hand ☐ Fingers, list digits:

Loss: ☐ Right Leg ☐ Left Leg at:
☐ Below Knee ☐ Above Knee ☐ Below Foot
☐ Above Foot ☐ Above Ankle ☐ Below Ankle

Date of Amputation:

COMPLETE FOR DISMEMBER AND/OR LOSS OF USE

Function totally and irrecoverably lost? ☐ Yes ☐ No ☐ Hand ☐ Fingers ☐ Hemiplegia ☐ Paraplegic ☐ Quadriplegic
☐ Other (coma, hearing, etc.) please describe:

COMPLETE FOR LOSS OF SIGHT / VISUAL IMPAIRMENT

Visual Acuity at last observation Date: Uncorrected ☐ Right Eye ☐ Left Eye Date: Corrected ☐ Right Eye ☐ Left Eye

Is loss entire and irrevocable? ☐ Right Eye ☐ Left Eye ☐ Yes ☐ No Date deemed entire and irrevocable:

COMPLETE FOR ALL CLAIMS

Were the injuries received in the accident on the date specified solely and independently the cause of loss? ☐ Yes ☐ No

Did the accident arise out of employment or occur while patient was working? ☐ Yes ☐ No

Did this injury cause any period of disability? ☐ Yes ☐ No Last date worked: Return to work date: If currently disabled, estimate return to work date:

Briefly describe the duties the patient is unable to perform:

List any other facts you feel will assist us in our review:

I hereby certify that the above answers are true and complete to the best of my knowledge and belief.

Name of attending physician (please print) Telephone Number

Street Address City State ZIP

Signature ***X*** Date

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Proof of Accidental Injury, Dismembermet
Claimant's Statement

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CLAIMANT'S STATEMENT

1. Complete, Sign and Date your portion of the claim form including the Authorization for Release of Information and the Fraud Statement.
2. Have your Physician complete the Attending Physician's Statement.
3. Send all documents to the address listed above.

COMPLETE FOR ALL CLAIMS

Policy Number	Name of Group	Name of Employee	Telephone Number

Date of Birth	Social Security Number	Tax ID Number	Address

COMPLETE FOR DEPENDENT CLAIMS ONLY

Dependent's Name and Address	Relationship to Insured
	☐ Spouse ☐ Dependent Child ☐ Other

Full Time Student	If "Yes" and 18 years or older, Name and Address of School
☐ Yes ☐ No	

COMPLETE FOR ALL CLAIMS

Date of Injury	Nature of Injury

Briefly describe how injury occurred:

Under penalties of perjury, I certify: (1) that the number shown on this application is my correct Social Security or correct Taxpayer ID number; and (2) that I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (include a U.S. resident alien). The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out item (2) in this paragraph if you are subject to backup withholding and cross out item (3) in this paragraph if you are not a U.S. person (including a U.S. resident alien).

THERE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Print Claimant's Name | Signature of Claimant, with Title, if any

Witness Name | Witness's Signature

Address | Telephone number | Date

BY FURNISHING THIS BLANK INVESTIGATING CLAIM, THE COMPANY SHALL NOT BE HELD TO ADMIT THE VALIDITY OF ANY CLAIM OR TO WAIVE THE BREACH OF ANY CONDITION OF THE POLICY.

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Authorization for Release of Insormation

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Claimant's Name	Date of Birth	Social Security Number

I hereby authorize all of the people and organizations listed below to give BEST Life and Health Insurance Company, BEST Re, BEST Health Plans, Pension Administrators, B.E.S.T., and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- Any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- Any physician or medical practitioner;
- Any hospital, clinic or other health care facility;
- Any insurance or reinsurance company (including, but not limited to, the Recipient or any other BEST Family of Companies which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- Any consumer reporting agency or insurance support organization;
- My employer, group policyholder, or benefit plan administrator; and
- The Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- Determine my eligibility for benefits under and/or the contestability of an insurance policy; and
- Detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the BEST Life and Health Insurance Company Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request: BEST Life and Health Insurance Company, P.O. Box 890, Meridian, ID 83890. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Signature of Claimant/Guardian/Representative Date

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.

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.

Alabama: 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 restitution fines or confinement in prison, or any combination thereof.

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."

Arkansas: The following statement is required by Arkansas Law
23-66-503(a): 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.

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.

Colorado: COLORADO LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any 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 insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DC: The District of Columbia requires us to notify you of the following:
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: FLORIDA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: 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.

Hawaii: Hawaii Law requires us to notify you of the following: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Idaho: IDAHO LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly, and with intent to defraud any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: INDIANA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: A 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.

Kentucky and 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.

Louisiana and Rhode Island: 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.

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 Mexico: New Mexico state law requires us to notify you of the
following: 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 guilt of a crime and may be subject to civil fines and criminal penalties.

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.

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.

Oregon: 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 may be a crime and may subject such person to criminal and civil penalties.

Pennsylvania: THE COMMONWEALTH OF PENNSYLVANIA REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: 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.

Tennessee: TENNESSEE STATE LAW REQUIRES US TO NOTIFY YOU OF THE
FOLLOWING: "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."

Texas: Texas law requires us to notify you of the following: 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.

Virginia: THE COMMONWEALTH OF VIRGINIA REQUIRES US TO NOTIFY YOU OF THE
FOLLOWING: 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.

Washington: THE STATE OF WASHINGTON REQUIRES US TO NOTIFY YOU OF THE
FOLLOWING: "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."

All other states: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.