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 Death
Group Term Life

STATEMENT OF POLICYHOLDER

Name of Deceased Employee	Phone Number	Date of Employee's Birth	Date of Employee's Death

Address of Employee	Group Policy No.	Certificate No.	Amount of Life Insurance

Name and Address of Employer	Phone Number	Type of Employment
		☐ Union ☐ Non-Union ☐ Full Time ☐ Part Time

Hours Worked Per Week	Weekly Earnings	Duration of Employment	Disability Benefits were Paid	Carrier's Name
		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:

Beneficiary (if estate, attach a certified copy of court order appointing executor or administrator)

Name and Address	Relationship	Age

Guardian (if beneficiary is a minor, attach a certified copy of court order appointing guardian)	Send correspondence and check to
Full Name and Address	

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

Print Name of Signature Above Telephone Number

ATTENDING PHYSICIAN'S STATEMENT

If the deceased was disabled more than 31 days prior to death, please have this statement completed by the physician who treated during this disability.

Name of Deceased	Date of Death	Age

Place of Death	Date of first visit	Date of last visit

Immediate Cause of Death	Duration

Contributory Causes or Complications	Duration	Death Resulted From
		☐ Natural Causes ☐ Accident ☐ Suicide ☐ Homicide

If due to accident, suicide, or homicide, describe briefly	The Deceased was totally disabled and unable to perform work
	From Through

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

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.

PLEASE COMPLETE REVERSE

CLAIMANT'S STATEMENT

Full Name of Deceased	Date of Birth	Date of Death

Cause of Death	Place of Death

Provide date that deceased first complain of, or give indication of his/her last illness	Provide date that deceased first consulted a physician for last illness

Was death result of an accident?	Date of Accident	Place of Accident	Did accident occur in the course of employment?
☐ Yes ☐ No			☐ Yes ☐ No

Describe accident briefly

Names and addresses of all physicians who attended the deceased and of all hospitals and institutions where he/she was treated during the last illness and during five years prior thereto

Name	Address	Date	Disease/Condition

Facts concerning other life, health and accident insurance carried by deceased.

Company	Policy Number	Amount of Insurance

Original certificate of insurance must be returned if available	In what capacity did you claim this insurance (if administrator, executor or guardian, attach copy of court order appointment)
☐ Certificate enclosed ☐ Certificate cannot be located	

Your Date of Birth	Your Social Security Number	Estate Tax ID/Trust Tax ID (provide if claim made by estate or trust)

I elect to receive payment by ☐ lump sum direct payment by check.
☐ other settlement option (Please specify and if necessary, contact your insurance plan administrator for a description of other settlement options available) _____.

These statements are true and complete to the best of my knowledge and belief. I understand that the furnishing of forms by the Company does not constitute an admission that there is any insurance in force. I hereby authorize and request any hospital, physician, pharmacist, employer, insurance company or other person or entity to whom this is presented to furnish BEST Life and Health Insurance Co. or its representative, any and all information and records (or copies thereof) it may desire, specifically to include testing and/or treatment of Human Immunodeficiency (HIV) or AIDS, concerning the deceased and further agree that such information or records shall constitute and are hereby made a part of the Proofs of Death. A photostatic copy of this authorization shall be as valid as the original. Furthermore, in the event an instant access account is opened, the Signature of Claimant(s) presented on this claim form will be used for signature verification.

Under penalty of perjury, I certify that the Social Security/Tax ID number provided on this form is true, correct, and complete. I understand that failure to furnish this number can subject me to back-up withholding. I certify that I am not now subject to back-up withholding.

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

Witness | Date

Address | Telephone number

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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INSTRUCTIONS FOR FILING A GROUP DEATH CLAIM

In order to ensure that we provide prompt service and to be as helpful to you as possible, please submit the enclosed claim form with all three sections completed as follows:

The "Statement of Policyholder" section is to be completed and signed by an authorized representative of the policyholder (employer).

The "Attending Physician's Statement" section is only to be completed if the deceased was disabled for at least 31 days preceding death. Only a physician who treated for the disability should be asked to complete this section.

The "Claimant's Statement" section is to be completed and signed by the designated beneficiary. If no beneficiary has been designated, then the statement should be completed and signed by either the Executor or Administrator of the decedent's estate. Certified estate papers should also be submitted along with the claim. In the event the designated beneficiary is a minor, the Guardian of the Property/Estate of such minor beneficiary will need to complete and sign this section. Certified guardianship papers will also be required at the time of submission.

Return the Proof of Group Death Claim Form with

(1) an original or certified copy of the death certificate,
(2) the deceased's certificate of insurance and
(3) the original enrollment card

If death took place in a foreign country and the death certificate was issued by that country, it should be certified by an official of the American Consulate within that country.

In the event that your life insurance is based on salary, please forward a copy of the decedent's pay records for the last quarter of full-time active work.

The claim form will be processed once the Company has received all of the above items along with a completed claim form. By furnishing this form and requesting material, the Company does not waive any defenses or rights it has or may have relating to this matter.

For questions, please call our Claims Department at (800) 433-0088. All documents should be mailed to:

BEST Life and Health Insurance Company
P.O. Box 890
Meridian, ID 83680
(800) 433-0088

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.