

P.O. Box 890, Meridian, ID 83890 (800) 433-0088

| STATEMENT OF POLICYHOLDER | | | | | |
|--|---|-----------------------------------|--|-----------------------------------|--|
| Name of Employee | | | Address of Employee | | |
| | | | | | |
| Group Policy No. | Certificate No. | Amount of Insurance for Dependent | Duration of Employment | Last day of full time active work | |
| | | | From Through | | |
| Name and Address of Employer | | Phone Number | Reason for stopping work | | |
| | | | <input type="checkbox"/> Illness <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Retirement <input type="checkbox"/> Lay Off <input type="checkbox"/> Other: | | |
| Full Name of Deceased Dependent | | Relationship to Employee | Dependent's Date of Birth | Date of Death | |
| | | | | | |
| Is dependent married? | If contributory insurance, what date has employee's contribution been paid? | | If full time student, name and address of school attended | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Is dependent employed full time? | If yes, Name and Address of dependent's employer | | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Name of Beneficiary | | Relationship to Beneficiary | | Age of Beneficiary | |
| | | | | | |
| Signature of Policyholder's Official Representative X | | Title | | Date | |
| | | | | | |
| Print Name of Individual Whose Signature Appears Above | | Sent Check To | | | |
| | | | | | |
| 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 | | |
| | | | | | |
| In what capacity do you claim this insurance? (If administrator, executor or guardian, attach a copy of court order of appointment.) | | | | | |
| | | | | | |
| Your Date of Birth | Your Social Security Number | | If lump-sum settlement is NOT elected, indicate Optional Mode of Settlement desired | | |
| | | | | | |
| <p>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.</p> <p>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.</p> | | | | | |
| 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.

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.



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, union, association, welfare fund or other organization through which the insurance was obtained).

The “Claimant’s Statement” section is to be completed and signed by the designated beneficiary (usually the insured employee). Anyone other than a family member may sign as witness to the beneficiary’s signature.

Return the Proof of Group Death Claim Form with

- (1) an original or certified copy of the death certificate,
- (2) a copy of the deceased’s certificate of insurance and
- (3) the original enrollment card, if available

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.

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 83890
(800) 433-0088