



THE EPIC LIFE INSURANCE COMPANY

Life, AD&D, Living/Accelerated Benefit Claim Form Instructions

- Section A: General Information** – to be completed by the employer’s authorized representative.
- Section B: Circumstances of Death** – to be completed by the employer’s authorized representative.
- Section C: Accident Information** – to be completed by the family’s or the employer’s authorized representative. If due to an accident, attach a copy of the accident report, medical examiners report or coroners report.
- Section D: Beneficiary Information** – to be completed by the family’s or the employer’s authorized representative. For additional space, attach a separate sheet.
- Section E: Attending Physicians Statement** – to be completed by the employee’s attending physician(s). Please complete this section if the employee is applying for Living/Accelerated Benefits.
- Section F: Release of Information** – to be completed by the family’s authorized representative.

Life Insurance Claim Requirements

- Completed claim form.
- Notarized copy of the Death Certificate.
- Copy of the individual’s application (for beneficiary verification).
- Copy of the previous year’s W-2 form.
- If due to an injury or accident (MVA, suicide, etc.):
 - Copy of the police report.
 - Copy of the autopsy report, including toxicology results.
 - Any newspaper articles or obituary.
- Medical records may be requested if the death occurred within two years of the effective date.

Questions/Assistance

For questions or assistance, please contact EPIC’s Life and Disability Claims Department at 800-520-5750 or life&diclaims@epiclifecom.

Submitting Your Claim

Please ensure all three sections of your claim form are fully completed and signed. Please send your claim form and documentation to:

The EPIC Life Insurance Company
Attention: Life & Disability Claims
P.O. Box 8430
Madison, WI 53708-8430

P.O. Box 8430 – Madison, WI 53708-8430
Phone: 608-223-2100 Toll Free: 800-520-5750 Fax: 608-223-2159
www.epiclifecom



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P.O. Box 8430, Madison, WI 53708-8430

Life, AD&D, Living/Accelerated Benefit Claim Form

Life Claim (Parts A-D,F)

AD&D Claim (Parts A-D,F)

Supplemental Life Claim (Parts A-D,F)

Living/Accelerated Benefit Claim (Parts A,E,F)

A. Employer Completes		General Information		
Name of Insured Group		Address of Insured Group		
Telephone		City	State	Zip
Policy Number	Certificate Number	Effective Date of Insurance	Date Premium Paid for Insured	Amount of Insurance
Full Name of Insured Employee	Address of Insured Employee		Annual Salary of Employee	Employee Social Security No.
Full Name of Deceased/Patient	Address of Deceased/Patient		Relationship to Employee	Deceased/Patient on Premium Waiver?
B. Employer Completes		Circumstances of Death		
Date of Death	Place (if hospital or institution, provide name and address)	Date Sickness Commenced	Date physician first consulted for last sickness.	
Was deceased considered an active eligible employee/dependent at time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Date Employee Last Worked	Reason for Stopping Work			
Date Completed	Signature of Employer's Authorized Representative		Title (officer of the company)	
C. Family Completes		Accident Information		
If due to accident, attach a copy of the accident report, medical examiners report or coroners report.				
Date of Accident	Was accident on the job or arise out of, or in the course of, deceased's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Describe how, where, and when fatal injury occurred and nature of injuries sustained.				

D. Family Completes**Beneficiary Information****For additional space, attach separate sheet.**

Name of Beneficiary	Social Security Number	Relationship	Date of Birth
Address	City	State	Zip
Name of Beneficiary	Social Security Number	Relationship	Date of Birth
Address	City	State	Zip

E. Attending Physicians Statement

Name of Patient		Date of Birth	
When did symptoms first appear or accident happen?	Date patient ceased work because of disability?	Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes state when and describe.	
Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Names and addresses of other treating physicians.		
Diagnosis (including complications)	Subjective Symptoms		
Objective Findings (including current x-rays, EKG's, laboratory data and any clinical findings)			
Date of First Visit	Date of Last Visit	Frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify)	
Nature of Treatment (including surgery and medications prescribed, if any)			
Has Patient: <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Retrogressed		Is Patient: <input type="checkbox"/> Ambulatory <input type="checkbox"/> House confined <input type="checkbox"/> Bed confined <input type="checkbox"/> Hospital confined <input type="checkbox"/> Hospice care	
Has patient been hospital confined? If yes, provide name and address of hospital. Confined from _____ through _____			
Please indicate patient's long-term and short-term prognosis (including life expectancy).		Indicate duration of illness (from initial onset to present).	
Print Attending Physician Name		Medical Specialty	Telephone
Address	City	State	Zip
Signature			Date

**AUTHORIZATION TO DISCLOSE HEALTH-RELATED INFORMATION
(This Authorization complies with the HIPAA Privacy Rule)**

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility or provider, clearinghouse, health plan, insurance or reinsuring company, agent, broker, service provider, credit bureau or other consumer reporting agency, employer, the Veterans Administration, the Medical Information Bureau, Inc., or any other personal or business associate to disclose any and all "Information" about me to The EPIC Life Insurance Company, its employees, agents or representatives ("EPIC Life"). "Information" may include my entire medical record, diagnosis, prognosis, prescription history, medicines prescribed, treatment or care of any physical or mental condition concerning me, including information about HIV/AIDS, drug or alcohol abuse or mental illness (excluding psychotherapy notes), and/or financial, consumer report, or any other medical or non-medical information about me.

The Information to be disclosed under this Authorization may be used by EPIC Life to: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities relating to any coverage I have or have applied for with EPIC Life.

I understand that I have the right to revoke this Authorization at any time by providing written notice of revocation to EPIC Life. I am aware that my revocation will not be effective until received by EPIC Life and will not be effective regarding the uses and/or disclosures of my Information that EPIC Life has made prior to receipt of my revocation. If the authorization was obtained as a condition of obtaining insurance coverage, other law provides EPIC Life with the right to contest a claim under the policy or the policy itself. A copy of this form shall be as valid as the original.

I understand that I am under no obligation to sign this Authorization but that my refusal to sign it may prevent EPIC Life from being able to process my application for coverage, determine my eligibility or make benefit payments. My physician or other health care provider may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that once Information is disclosed under this Authorization, it may no longer be protected by federal privacy rules and may be re-disclosed by the person or entity that receives it. I am entitled to keep a copy of this form for my records. This Authorization shall expire 30 months from the date signed.

I certify that the information I have provided on this form is true, complete, and accurate to the best of my knowledge and belief. I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss may be subject to imprisonment, fines, denial of insurance, and/or civil damages.

_____	_____
Name of Claimant	Claimant's Date of Birth
_____	_____
Signature of Authorized Representative*	Date Signed

*Authorized Representative's Authority or Relationship to Claimant (attach any supporting documentation)

MAIL TO:

The EPIC Life Insurance Company - Attn: Life & Disability Claims P.O. Box 8430, Madison, WI 53708-8430

For Life Benefits - A NOTARIZED COPY OF THE DEATH CERTIFICATE MUST ACCOMPANY THIS FORM

FLORIDA / IDAHO RESIDENTS - REQUIRED NOTICE 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.

NEW YORK RESIDENTS - REQUIRED NOTICE 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 concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.