SENIOR LIFE INSURANCE COMPANY

Claim Form

Senior Life Insurance Company
P.O. Box 2447
Thomasville, GA 31799-2447
1-877-777-8808
A Georgia Stock Company • Executive Offices: Thomasville, Georgia

AUTHORIZATION – MEDICAL INFORMATION FOR FILING A DEATH CLAIM

"I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility or insurance company that has any records or knowledge of the deceased or the deceased's health to give to the Claims Department of Senior Life Insurance Company or its reinsurers any such information including mental, alcohol, drug or HIV (Human Immunodeficiency Virus) related information for the purpose of assessing the pending claim. This authorization may be used for the duration of the pending claim. I may request and receive a copy of any medical information obtained with this authorization. A photostatic copy of this authorization shall be as valid as the original. I declare that I am of legal age to file this claim."

_____ Name of Deceased

_____ Next of Kin (print name)

_____ Policy #

_____ Street Address

_____ Relationship to Deceased

_____ City State Zip

If death has occurred within 2 years of issue/reinstatement date or if the death was by Accidental means, list the doctors/hospitals that treated the insured in the **5 years prior to the application date.**

Primary

Doctor _____

Address _____

City _____ St_____Zip _____

Phone (_____)_____

Doctor _____

Address _____

City _____ St_____ Zip _____

Phone (_____)_____

Hospital _____

Address _____

City _____ St_____Zip _____

Phone (_____)_____

Clinic _____

Address _____

City _____ St_____ Zip _____

Phone (_____)_____

Dated this _____ day of _____, _____

X_____
Signature of Next of Kin

PLEASE COMPLETE THE APPROPRIATE INFORMATION ON REVERSE SIDE OF THIS FORM.

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.

BENEFICIARY INFORMATION

Name of Beneficiary _____ Relationship _____

Address _____ City _____ St _____ Zip _____

Social Security # _____ Phone # (_____)_____ Date of Birth _____

Name of Beneficiary _____ Relationship _____

Address _____ City _____ St _____ Zip _____

Social Security # _____ Phone # (_____)_____ Date of Birth _____

ASSIGNMENT OF PROCEEDS OF INSURANCE

I, _____, being entitled to receive benefits under Policy # _____
(Beneficiary)

issued by Senior Life Insurance Company on the life of _____,
(Deceased/ Insured)

now deceased, and having contracted with and being indebted to _____
(Funeral Home)

of _____ for funeral services and merchandise for the deceased, do
(Address, City, State, Zip)

hereby set over, assign and transfer unto said Funeral Director the sum of _____

Dollars ($_____) out of the proceeds of said Insurance Policy; and I hereby authorize and direct Senior Life Insurance Company to make its check payable to said Funeral Director for the assigned amount and to pay the remainder of the proceeds of said Insurance Policy, if any, to me.

_____ _____ **NOTARY SEAL**
(Beneficiary Signature) (Beneficiary Signature)

Sworn and subscribed before me the _____ day of _____, _____

NOTARY PUBLIC _____ My commission expires _____

AFFIDAVIT FOR LOST POLICY

I, the undersigned, hereby certify that Policy # _____ issued on the life of _____ by the Company has been lost or destroyed.

Beneficiary Signature _____ Date _____

BENEFICIARY CERTIFICATION

Checklist:

❒ Certified Death Certificate ❒ Original Policy/Affidavit for Lost Policy ❒ Form CL3210_03 ❒ Form HIPAA05_03

By signing below I, the Beneficiary, certify that the statements in this form are true to the best of my knowledge and that all necessary paperwork has been completed according to the above checklist.

Beneficiary Signature _____ Date _____

Beneficiary Signature _____ Date _____

Authorization for Release of Health Information to:
Senior Life Insurance Company
P.O. Box 2447
Thomasville, GA 31799-2447

This Authorization complies with the HIPAA Privacy Rule

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as Medical Information Bureau, Inc.) or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Senior Life Insurance Company (the "Company") and its agents, employees, and representatives. This includes information on the diagnosis or treatment of HIV (Human Immunodeficiency Virus), AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted diseases, information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct My Providers to release and disclose the entire medical records without restrictions.

This protected health information is to be disclosed under this Authorization so that the Company may:

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 that relate to any coverage I have or have applied for with the Company.

I understand that this Authorization shall remain in force for 24 months (180 days for HIV-related information) following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company, Attention: HIPAA Privacy Official to the address listed above. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that this Authorization was provided as a condition of obtaining insurance coverage and other law provides the Company with the right to contest a claim for coverage under the policy or the policy itself. I understand that any information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information. However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical records, the Company may not be able to process my application, or if coverage has been issued, may not be able to process policy claims and/or make any benefit payments. I am entitled to receive a copy of this Authorization. My Personal Representative is also entitled to receive a copy of this Authorization.

Proposed Insured's Printed Name	Date of Birth	Social Security Number

Proposed Insured's or Authorized Representative's Signature	Date

Description of Authorized Representative's Authority with appropriate documents attached (if applicable)

SENIOR LIFE
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®

Helping families since 1970

SENIOR LIFE INSURANCE COMPANY

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Thomasville, Georgia 31799

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