PACIFIC LIFE

Accelerated Benefit Option

Employer Claim Statements Package

This package is to be used by Employers who want to file an Accelerated Benefit Option claim on behalf of an employee/member who has been diagnosed with a terminal illness and and meets timeline requirements for life expectancy (e.g., less than 12 months). The following forms are included:

- Claim Fraud Statements
- Group Life Insurance Accelerated Benefit Option - Employer Claim Statement Instructions
- Group Life Insurance Accelerated Benefit Option - Employer Claim Statement
- Group Life Insurance Accelerated Benefit Option - Employee Claim Statement
- Authorization for the Use and/or Disclosure of Information
- Group Life Insurance Accelerated Benefit Option - Attending Physician Statement

Pacific Life & Annuity Company
Workforce Benefits - Claims
PO Box 2387
Omaha NE 68103-2387
PH (855) 810-3301 Fax (949) 219-8872
claims.workforcebenefits@pacificlife.com

Group Life Insurance
Accelerated Benefit Option - Employer Claim Statement Instructions

Pacific Life is here to support you during this process. If you have any questions regarding this form or documentation required, please contact us at 855-810-3301 during the hours of 8 a.m. through 8 p.m. Eastern Time.

An Accelerated Benefit Option is a one-time payment of a portion of eligible life insurance benefits. An insured can qualify for the Accelerated Benefit Option by being terminally ill with a shortened life expectancy of typically 12 months or less (refer to your certificate for specific life expectancy requirements). Payment of an Accelerated Benefit Option will reduce the life insurance amount by the amount of the benefit received.

Claim Submission Instructions:

When filing a claim for the Accelerated Benefit Option, please provide the following:

1. Complete the **Group Life Insurance - Accelerated Benefit Option - Employer Claim Statement**
   - Review the fraud notices in and sign the document
   - We may request payroll documentation to calculate the benefit per the earnings definition as defined in the policy
   - Be sure to complete each section about the employee.
2. Provide the employee with the following
   - **Accelerated Benefit Option – Employee Claim Statement**
   - **Attending Physician Statement for Accelerated Benefit Option**
   - **Authorization for the Use and/or Disclosure of Information**
   - **Authorization for Release of Claim Information**
3. Please notify the employee that we will also require
   - **Attending Physician Statement for Accelerated Benefit Option**
   - Medical records and hospital records supporting the terminal condition.
   - Authorization for Release of Claim Information to contact medical providers (if necessary)
4. Return the documents to us by one of the following methods:
   - Email: claims.workforcebenefits@pacificlife.com
   - Mail: Pacific Life – Workforce Benefits Claims, PO Box 2387, Omaha, NE 68103-2387
   - Fax: (949) 219-8872

Employee documents can be submitted separately upon completion

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Group Life Insurance
Accelerated Benefit Option - Employer Claim Statement

Section 1: Information About the Employer

Employer Name:	Policy Number:
Employer Address:	City: State: ZIP Code:
Name of Person Completing the Form:	Title of Person Completing the Form:
Telephone Number:	Email:

Section 2: Information About the Employee

Employee Name (First, MI, Last):	Employee Social Security Number:	Date of Hire:	Effective Date of Employee Insurance:

Employment Status: ◯ Full-time ◯ Part-time ◯ Retired ◯ Exempt ◯ Non-Exempt

Is Employee actively at work? ◯ Yes ◯ No If No, date last worked _____ (mm/dd/yyyy)	Employee's Premium Paid through date:	Employee Terminated? ◯ Yes ◯ No If No, date last worked _____ (mm/dd/yyyy)	Insurance Class:	Location:
Date of Last Pay Increase:	Employee Pay: Hourly – Per Hour $_____ Salary – Annual Salary $_____		Check applicable: ☐ Commissions ☐ Bonuses ☐ Overtime ☐ Shift Differential	
Average Hours worked per Week:	Reason employee stopped working ◯ Illness/injury ◯ FMLA ◯ Resigned/Dismissed ◯ Retiree ◯ Other:			

Section 3: Employer Signature

I hereby verify that the information provided on this claim form is complete and accurate in accordance with employer records.
I am authorized to provide this information on behalf of the employer.

Signature: _____ Date: _____

Name: _____ Title: _____

Telephone Number: _____ Email: _____

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Group Life Insurance
Accelerated Benefit Option - Employee Claim Statement

Section 1: Employee Information

Name (Last) (First)	(MI)	(Suffix)	Date of Birth (mm/dd/yyyy):	Social Security Number:

Address:	City:	State:	ZIP Code:

Telephone Number:	Email:	Marital Status:

Section 2: Employee Medical Condition

Medical condition: _____

Dates Symptoms were first noticed: _____ Date first treated: _____

Please indicate all physician(s) that have been seen for this condition:

Physician Name _____ Phone _____

Physician Address _____ City _____ State _____ ZIP _____

Physician Specialty_____

Physician Name _____ Phone _____

Physician Address _____ City _____ State _____ ZIP _____

Physician Specialty_____

Have you been hospitalized? ◯ Yes ◯ No If yes, please provide the dates of hospitalization:

From _____ To _____ From _____ To _____ From _____ To _____

Hospital Name _____ Phone _____

Hospital Address _____ City _____ State _____ ZIP _____

Are you required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise? ◯ Yes ◯ No

Have you assigned an irrevocable beneficiary or assignee to this policy? ◯ Yes ◯ No

Are you required by a government agency to use this benefit in lieu of applying for, obtaining, or otherwise keeping a government benefit or entitlement? ◯ Yes ◯ No

Section 4: Benefit Amount Requested

Amount of Accelerated Benefit Option requested.

Basic Life: $ _____ Supplemental Life: $_____

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Section 5: Signature

By signing the Signature section, I attest that:

- The answers provided in this statement are true and complete to the best of my knowledge.
- I have read and understand the information in the Claim Fraud Statements section.
- The receipt of an Accelerated Benefit Option payment, if eligible and approved, may be taxable.
- The receipt of an Accelerated Benefit Option payment may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income.
- I understand any payments Accelerated Benefit Option payment will decrease the Life Insurance Benefit amount by the amount I receive.
- I understand that I may consult with an independent financial, tax, or legal advisor, as needed. Pacific Life & Annuity Company will not provide me with any financial, tax, or legal advice or recommendations.

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATIONS REQUIRED TO AVOID BACKUP WITHHOLDING.

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 material 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature: _____ Date: _____

Print Name: (include Title/Capacity, if applicable) _____

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Authorization for the Use and/or Disclosure of Information

Claimant/Employee/Retiree Name: ..... DOB: .....

I authorize the use and disclosure of the following information so that Pacific Life & Annuity Company can evaluate the insurance claim on the above-named individual.

1. This authorization applies to the following information (whether from before, during or after the date of this authorization):

Any and all medical records: this includes, to the extent that the medical records include such information, information about HIV status, AIDS, other communicable or sexually transmitted diseases, mental health (other than "psychotherapy notes" that are kept separate from the medical record), any substance use disorder, and/or genetic information. Additionally, workers compensation information; postmortem examination, autopsy, toxicology records and reports; investigative reports; accident reports by law enforcement; paramedics records; employment incident reports; incident reports of any kind; photographs; insurance information; insurance claims records; financial and employment related information; and information regarding social security or other government benefits including benefit amounts and entitlement dates.

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of this information:

Health care professionals, hospitals, clinics, laboratories, pharmacies, emergency medical service agencies and all other medically related providers; medical examiner's offices, coroner's offices, health plans, insurance companies, third party administrators, law enforcement agencies, public safety departments, government agencies and entities (including to but not limited to federal, state, local and Social Security Administration), insurance producers, insurance service providers, credit bureaus, professional licensing bodies, consumer reporting agencies, reinsurers, employers, attorneys, financial institutions and/or banks.

3. I authorize the following persons (or class of persons) to receive this information:

Pacific Life & Annuity Company and its parent company.

4. Purpose of proposed use or disclosure:

For purposes of Pacific Life & Annuity Company evaluating and administering insurance claims.

5. I authorize Pacific Life & Annuity Company to share this information with:

The Group Insurance Plan as needed to perform its responsibilities under any benefit plan for the purpose of reporting claim status or experience, or so that the recipient may carry out health care operations, claims payment, administrative, or audit functions related to any benefit, plan or claim.

6. This authorization expires:

One year after the date of signature.

REFUSAL TO SIGN:

You may refuse to sign this authorization*. A health care provider or health plan may not condition treatment, payment, enrollment, or eligibility for health plan benefits on your providing or refusing to provide this authorization. Your failure to sign this authorization, however, may result in Pacific Life & Annuity Company being unable to approve and pay this insurance claim.*

REDISCLOSURE:

Once your information is disclosed pursuant to this authorization, it may no longer be subject to federal and state law and may be subject to redisclosure. Pacific Life & Annuity Company will protect the privacy of this information in accordance with its privacy policy and other applicable law. For more information, you may visit https://www.pacificlife.com/home/privacy-and-other-policies/our-privacy-promise.html

REVOCATION:

You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to Pacific Life & Annuity Company at: PO Box 2387, Omaha, NE 68103-2387. Your revocation will not be effective to the extent that health care providers or health plans have already acted in reliance upon this authorization.

COPY OF AUTHORIZATION

You may request a copy of this authorization.

AUTHORIZATION

I understand and agree to the foregoing:

Signature ..... Date .....

Print Name .....

If signing as legal representative, describe your authority:

.....

Supporting Documentation must be attached.

....
Signature of Individual or Personal Representative Date

Printed name of Personal Representative .....

Relationship to Insured/Member .....

(e.g. LEGAL GUARDIAN, EXECUTOR, ADMINISTRATOR, OR NEXT-OF-KIN)

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Claim Fraud Statements

Please read the warning for your state.

General Fraud Warning: Any person who knowingly presents a false statement in a claim for insurance may be guilty of a criminal offense and subject to penalties under state law. (Not applicable in Virginia)

The laws of each state listed below require us to furnish you with the notice indicated below.

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.

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.

District of Columbia: 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: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: 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.

New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

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Group Life Insurance
Accelerated Benefit Option - Attending Physician Statement

Section 1: Information About the Patient (To be completed by patient)

Name (Last) (First)	(MI)	(Suffix)	Date of Birth (mm/dd/yyyy):	Social Security Number:

Phone Number:	Address:

Section 2: Information About the Medical Condition

Primary Diagnosis include ICD or DSM code and Description: _____ Date of Diagnosis: _____

Secondary Diagnosis include ICD or DSM code and Description: _____ Date of Diagnosis: _____

Date of first office visit? (mm/dd/yyyy)	Most recent visit? (mm/dd/yyyy)	How often do you see this patient?

Symptoms resulted from? ◯ Illness ◯ Accident	When did symptoms first appear? _____	Has patient had the same or similar condition previously? ◯ Yes ◯ No If yes, please describe. _____

Have you determined the condition is terminal? ◯ Yes ◯ No If yes, please provide the date the condition became terminal: _____

If yes, how many months is the life expectancy? _____ months

Objective Findings: (include copies of any X-rays, lab tests, EKGs, MRIs, scans, and office notes)

Have you referred the patient to other specialists/physicians: ◯ Yes ◯ No

Please indicate name(s) and telephone number(s): _____

Has patient been hospitalized? ◯ Yes ◯ No

If yes, please provide details: _____

_____

Hospital Name _____ Phone _____

Hospital Address _____ City _____ State _____ ZIP _____

Dates of Confinement: From _____ To _____ From _____ To _____

From _____ To _____ From _____ To _____

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Section 3: Signature of Attending Physician – The above statements are accurate and complete to the best of my knowledge and belief. Additionally, all supporting documentation on which the Physician's statement is based have been provided.

Physician Name _____ Specialty _____

Address _____ City _____ State _____ ZIP _____

Telephone _____ Fax _____

Signature of Attending Physician _____ Date _____

I have included the following:

☐ Lab results ☐ Office Notes ☐ MRIs ☐ Scans ☐ EKGs ☐ X-rays ☐ Other: _____

Please return this completed form and records by mail, fax, or email to:
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