



**Great Western  
Insurance Company**  
A Wellabe Company

## Death Claim Form

### Submitted to Wellabe, Inc. (the “Company”)\*

The furnishing of this form and investigation of the claim is not to be construed as an admission of the validity of any claim or as a waiver of any condition of the policy by the Company.

### Instructions for Filing a Claim

To avoid unnecessary processing delays, make sure you have:

- A completed and signed claim form
- A copy of the completed death certificate (need not be certified). Send within 30 days.
- Claims on First-Day coverage policies, within the two-year contestable period, need to have a completed death certificate indicating the cause of death attached to this claim form and the Medical Information Authorization, completed before payment will be made. Refund of premiums paid will be made immediately upon receipt of this form; all other amounts will be paid after the medical information and death certificate are received and reviewed.
- Claims on policies where the funeral home is not an assignee or beneficiary must be accompanied by a valid assignment with family signature and a filed death certificate.
- An itemized statement of all itemized bills for medical, hospital, or burial expenses actually incurred.

We suggest you keep a copy of all the information you send for your records.

### Fax or email the completed claim form and all other necessary documents to:

Fax: 801-675-4685

Email: [pnclaims@wellabe.com](mailto:pnclaims@wellabe.com)

### We're here for you:

If you have any questions, please call us at 800-995-9010, Monday through Friday, 7:30 a.m. to 5 p.m. Central time.

\* Great Western Insurance Company is a Wellabe company.

# Death Claim Form—to be completed by the funeral director/beneficiary/assignee

(Please print all information.)

Full name of insured (*first, middle, last, suffix*)

Policy Number

Social Security number

Date of birth

Date of death

Primary cause of death:  Natural  Accidental  Suicide

Is the Away-from-Home Benefit being applied for?  Yes  No

(This benefit is for death occurring 250 or more miles from primary residence, on a policy of \$2,000 or greater.)

Family representative arranging services: \_\_\_\_\_

Amount to be paid to funeral home:  Entire benefit **or**  Specific amount \$ \_\_\_\_\_ and  
the balance to \_\_\_\_\_ (please provide address below).

I certify as a legal representative of the listed funeral home that:

1. We are providing the funeral services and merchandise for the deceased insured,
2. We have legal claim on the proceeds of the policy by assignment or as beneficiary and authorize their release,
3. We agree that this payment will discharge in full all liability of the company under the policy(ies), and
4. We will indemnify the Company, if the policy proceeds are paid to us incorrectly.

Funeral home name

License number

Address

City

State

ZIP code

Signature of licensed funeral director/  
funeral home representative

Telephone number

Date

I certify that I am the beneficiary of the policy(ies) listed above and entitled to grant release of the proceeds. I agree that such payment shall discharge all liability of the Company under the policy(ies).

Signature of beneficiary/legal family representative

Date

Address

City

State

ZIP code

# Medical Information Authorization

Please PRINT and complete if claim is during the first two policy years of an underwritten policy.

Claims on policies where the funeral home is not an assignee or beneficiary must be accompanied by a valid assignment with family signature and a filed death certificate.

I hereby request and authorize any healthcare provider, medical facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, health plan, insurance company, Medical Information Bureau, Inc., claims administrator, government agency, or other person or firm, having information with respect to any illness, medical history, consultation, prescriptions, or treatments, including x-ray images/plates and copies of all hospital or medical records pertaining to the person listed below to release and provide any and all such information to Wellabe, Inc. ("the Company") or its legal representative:

\_\_\_\_\_  
Printed Name of Insured

The information requested and authorized is to be used in establishing the extent of the Company's liability in a death claim which has been filed for the above person. This authorization may be revoked by written notice to the Company at its Executive Offices in Iowa at any time after this authorization has been signed. Any information obtained will not be released by the Company to any persons or organizations except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with said claim, unless permitted by law, in which case it may not be protected under federal privacy rules. I understand that I or any authorized representative will receive a copy of this authorization upon request.

I agree that, unless specifically revoked by written notice to the Company, this authorization will be valid for 120 days after it has been signed. I know that I may request a copy of this authorization. I agree that a copy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
Signature of next of kin, family representative, or legal representative      Date      Telephone number

\_\_\_\_\_  
Address      City      State      ZIP code

## Physician's Information

Please list the physician(s) who treated the deceased during the two years prior to issuance of the policy.

\_\_\_\_\_  
Physician/Facility name      Telephone number

\_\_\_\_\_  
Address      City      State      ZIP code

\_\_\_\_\_  
Physician/Facility name      Telephone number

\_\_\_\_\_  
Address      City      State      ZIP code

**For your protection state law requires the following statements to appear on this form.**

**FRAUD WARNING STATEMENT**

<b>Alabama</b>	Any person who knowingly presents 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.
<b>Arkansas, Louisiana, and West Virginia</b>	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.
<b>Colorado</b>	It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an 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.
<b>Florida</b>	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.
<b>Kansas</b>	Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be guilty of insurance fraud as determined by a court of law. Use of the mail to defraud is a violation of federal law.
<b>Kentucky</b>	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
<b>Maine, Tennessee, Virginia, and Washington</b>	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.
<b>New Mexico</b>	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.
<b>Ohio</b>	Any person who, with intent to defraud or knowing that he or she 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.
<b>Oklahoma</b>	Any person who knowingly, and with intent to injure, defraud or deceive, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
<b>Oregon</b>	Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud may be a violation of federal law.
<b>Pennsylvania</b>	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.
<b>Residents of All Other States</b>	NOTICE: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud is a violation of federal law.

The furnishing of forms does not constitute an admission of liability on the part of the Company.