Erie Insurance®

Member Company
Erie Family Life Insurance Company

Home Office • 100 Erie Insurance Place • Erie, Pennsylvania 16530 • 814.870.4340
Toll free 1.800.458.0811 Ext. 4340 • Fax 814.461.1238 • erieinsurance.com

CLAIMANT'S STATEMENT

This form and the following documentation must be completed and returned to: **Erie Family Life, 100 Erie Insurance Place, Erie, PA 16530** in order to file a claim with Erie Family Life Insurance Company.

A. DEATH CERTIFICATE

A certified copy of the death certificate should be obtained and forwarded to the Home Office. Other documentation, such as notice from local newspaper, etc., particularly in the case of accidental death or possible suicide, is desirable but not required. Such additional data will NOT be accepted as a substitute for the death certificate. However, if death benefit is less than $2,000, or if you reside in the state of TN, this requirement may be waived or alternate documentation accepted.

Should any beneficiary be deceased, a death certificate of that beneficiary should also be furnished.

B. ORIGINAL POLICY OR POLICIES

The original policy should be secured and forwarded with the Claimant's Statement and the death certificate. If the original policy cannot be located, it should be so indicated on the Claimant's Statement.

C. SIGNATURE CERTIFICATION

Claimant must forward one of the following forms of signature certification:
A notarized signature on this Claimant's form or a clear copy of the beneficiary's driver's license or state ID card.

Note: All death claim settlements default to a lump sum settlement unless otherwise requested. If one of the alternate settlement options provided for in the policy is desired, please contact our Home Office at the number listed above, as additional documentation will be required.

Authorization - If the death occurred within the first two policy years or within two years of reinstatement, the Authorization contained in the claim form must be completed. The authorization should be completed by the executor of the estate, a certificate of whose appointment and qualifications must be furnished.

INSTRUCTIONS FOR COMPLETING THE CLAIMANT'S STATEMENT (Mailing Instructions for Proceeds, Part I and III should be completed for all claims)	
PART I	This form must be executed before a WITNESS by the person or persons to whom the insurance is payable. **If the policy is payable to the Estate, the statement should be completed and signed by the Executor of the Estate, with a copy of the court documents appointing said Executors.** ***A copy of the court documents appointing Executor must accompany this form - A copy of the will is NOT acceptable.*** If the policy is payable to a MINOR or a MENTALLY INCOMPETENT PERSON, a statement should be executed by a GUARDIAN. An official certificate of appointment and qualifications must be furnished. If the policy has been ASSIGNED ABSOLUTELY both in form and in fact, the statement should be executed by the ASSIGNEE. If the policy has been COLLATERALLY ASSIGNED, the statement should be executed by both the CLAIMANT(S) and ASSIGNEE and a statement agreed to by both parties should be furnished showing the extent of the assignee's interest in the policy. **If signing as Power of Attorney for the beneficiary, the following signature format must be followed: (Beneficiary's name) by and through (Power of Attorney's name) as POA. Example: Jane Doe, by and through John Doe as POA.** ***A copy of the POA paperwork must also accompany this form.****
PART II	This form and the AUTHORIZATION should be completed in all claims for Accidental Death Benefit or policies in force or reinstated within two years or less at the time of the insured's death.
PART III	Part IV of this form must be signed by the claimant and must be witnessed making a claim. Each claimant's signature must be witnessed.

INSTRUCTIONS FOR DEATH CLAIM PROCEEDS

☐ Return proceeds to Agent for delivery ☐ Mail proceeds directly to beneficiary ☐ Direct Deposit

☐ Other _____

_____ _____/____/_____
Name of Deceased Insured/Former Patient (please print) Date of birth

_____/____/_____
Date of death

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to the above-named deceased individual or on his/her behalf within the past 10 years ("Providers") to disclose the entire medical record and any other protected health information concerning the above-referenced individual to the Erie Family Life Insurance Company and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

This protected health information is to be disclosed under this Authorization so that Erie Family Life may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage the above-named deceased individual has or has applied for with Erie Family Life Insurance Company.

This authorization shall remain in force for 6 months 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 Erie Family Life Insurance Company at 100 Erie Insurance Place, Erie, PA 16530, Attention: Life Claims Department. I understand that a revocation is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that Erie Family Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical record, Erie Family Life Insurance Company may not be able to process this claim, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

_____ _____
Signature of Deceased's Personal Legal Representative Date

_____
Description of Deceased's Personal Representative's Legal Authority or Relationship to Insured/Patient

(Before completing, read instructions on first page.)

By furnishing forms and investigating the claim, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

(PLEASE TYPE OR PRINT)

PART I—DECEASED AND CLAIMANT (BENEFICIARY) INFORMATION—COMPLETE THIS SECTION FOR ALL CLAIMS.

Policies of this Company under which claim is being made:

POLICY NUMBER(S)	POLICY ISSUE DATE	AMOUNT OF INSURANCE	PLEASE INDICATE IF POLICY IS:
			☐ Attached ☐ Lost
			☐ Attached ☐ Lost
			☐ Attached ☐ Lost

1. a. Deceased's name in full _____ b. Please list any other name the Insured may have been known by such as maiden name, nickname or alias: _____
   c. Residence address _____
   d. Occupation at death _____ e. Date last worked _____
   f. Social Security No. _____
   g. Deceased's marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

2. a. Date of BIRTH of deceased _____ Place of birth _____
   b. Where was date of birth obtained? (Birth or Baptismal record should be consulted if possible.)
   _____

3. a. Date of DEATH _____ d. Place of death _____
   b. Cause of death _____
   c. Duration of illness _____

CLAIMANT (BENEFICIARY) INFORMATION:

a. Claimant Name _____
b. I am also known as _____
c. Claimant's Address _____
   City, State, ZIP _____
d. Claimant's Email Address _____
e. Phone No.: Home _____ f. Work _____ g. Cell _____
h. Taxpayer Identification No. (Social Security Number): _____
i. Relationship to Insured _____ j. Claimant's date of birth _____

PART II — PHYSICIAN AND HOSPITAL INFORMATION

THIS SECTION NEEDS ONLY TO BE COMPLETED IF THE DEATH OF THE INSURED OCCURRED WITHIN THE 2-YEAR CONTESTABLE PERIOD ON ANY OF THE POLICIES LISTED IN PART I OR IF A CLAIM IS BEING MADE FOR AN ACCIDENTAL DEATH BENEFIT.

5. Please complete the following:
   a. List the name and address of any physician(s) the insured has been treated by within the last three years.

PHYSICIAN'S NAME	ADDRESS

   b. List the name and address of any hospitals or institutions the insured has been treated at within the last three years.

HOSPITAL NAME	ADDRESS

   c. Provide the information concerning other life and/or accident insurance on the deceased.

NAME OF INSURANCE COMPANY	DATE OF POLICY	AMOUNT OF INSURANCE

6. Please indicate the manner of death as shown on the death certificate
   ☐ Natural Causes ☐ Homicide ☐ Undetermined ☐ Accident ☐ Suicide ☐ Pending
   * If beneficiary disagrees with the manner of death stated on the death certificate, please indicate below and provide an explanation:

PART III — DISBURSEMENT OF PROCEEDS

I elect to receive my proceeds via:

☐ Check
☐ Direct Deposit

- **A voided check or *letter from the bank must accompany this claim form.**
- **The claimant's (beneficiary's) name must be on the bank account for the deposit to be made.**
- **If the required direct deposit information is not received disbursement will default to payment via check.**

DIRECT DEPOSIT AUTHORIZATION FORM

I hereby authorize and request Erie Family Life to electronically transfer my payment(s) to my account in the institution indicated below.

BANK INFORMATION

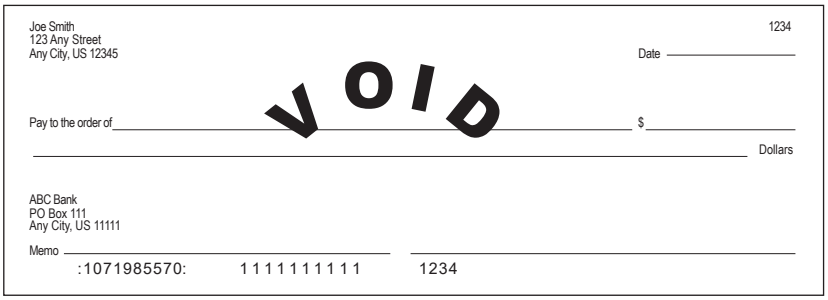
Bank Name	Branch	Telephone	
Address	City	State	ZIP
Select One ☐ Checking Account (provide a voided check) ☐ Savings Account (provide a *letter from the bank)			
Bank Routing Number	Account Number		

It is understood that this Direct Deposit Authorization may be revoked or changed by me at any time by providing written notice to Erie Family Life. To revoke or change please send a written notice to Erie Family Life at the address shown on page 1 of this form. It is agreed and understood that if an erroneous amount is credited to my account, Erie Family Life will reverse the full amount of the erroneous credit within five (5) days of the credit entry. Thereafter, Erie Family Life will electronically deposit the correct amount to the account as soon as practicable.

BENEFICIARY INFORMATION

Policy Number(s)	Daytime Phone Number	
Name on the Account	Signature	Date
Joint Name on the Account	Signature	Date
Email Address (An email confirmation will be sent to this address when the direct deposit is made.)		

Attach voided check below.



If you do not have a voided check or are requesting a direct deposit into your savings account, please provide a *letter from your bank on their letterhead providing the bank's routing number, the name of the account and the account number.

PART IV—CLAIMANT(S) SIGNATURE—COMPLETE THIS SECTION FOR ALL CLAIMS.

I declare that I have read and understood all the statements shown on this form, that they are true and complete to the best of my knowledge and correctly recorded.

Unless specific state language is noted below, the following general fraud notice applies and is part of the application:

GENERAL FRAUD NOTICE-Any person who knowingly presents a 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 fines and confinement in prison.

IN FRAUD NOTICE-A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KY FRAUD 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.

MD FRAUD NOTICE-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.

OH FRAUD NOTICE-Any person who, with intent to defraud or knowing that he 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.

PA NOTICE-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.

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

VA FRAUD NOTICE-Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Upon signing this claim form I understand that my payment selection is final and cannot be amended at a later date.

WITNESS	* CLAIMANT (BENEFICIARY) SIGNATURE	DATE

*** If signing as Power of Attorney, please see instructions.**

DO NOT MAIL BEFORE COMPLETING BELOW CHECKLIST

Have you enclosed the following?

- ☐ **Original death certificate**
- ☐ **Original policy (if lost check box on page 3 indicating lost)**
- ☐ **If electing direct deposit be sure to enclose a voided check for your checking account or a letter from your bank providing your account number and routing number for your savings account.**
- ☐ **Copy of your driver's license or state ID (if not having form notarized)**