__ Conseco Life Insurance Company
__ Conseco Life Insurance Company of Texas
P.O. Box 1917
Carmel, Indiana 46082-1917
(800) 525-7662

AGENT USE ONLY C14 ☐

Life Insurance Claim Form

FIRST MI LAST

DECEDENT

POLICY NUMBER DATE OF DEATH

A DECEDENT AND POLICY INFORMATION

SOCIAL SECURITY NUMBER DATE OF BIRTH

OTHER KNOWN NAMES OF DECEDENT

CAUSE OF DEATH

PLACE OF DEATH

☐ Proceeds have been assigned. (*Provide assignment documentation with Claim Form.*)

B CLAIMANT INFORMATION

NOTE: PROVIDE ADDENDUM OR SUBMIT ADDITIONAL CLAIM FORM IF MULTIPLE CLAIMANTS.

FIRST NAME MI LAST NAME

BUSINESS OR ENTITY NAME

ADDRESS 1

ADDRESS 2

CITY STATE ZIP

EMAIL

PHONE ALTERNATE PHONE

SOCIAL SECURITY NUMBER **OR** EMPLOYER IDENTIFICATION NUMBER

DATE OF BIRTH

RELATIONSHIP TO DECEDENT

C. PAYMENT OPTIONS

SELECT **ONE** DISBURSEMENT METHOD:

☐ BenefitNOW Account®

The BenefitNOW Account® is our primary method of paying insurance proceeds over $5,000.00. BenefitNOW is an interest bearing draft account. By simply writing a draft you have immediate access to your funds whenever you need them. BenefitNOW may not be available in all states or with some products. ***If a BenefitNOW account cannot be established, a single check will be issued unless you have selected a different option below.*** *Please see the enclosed insert for further advantages of the BenefitNOW Account option.*

☐ Single Check Payment

☐ Proceeds on Deposit

☐ Other _____

Refer to policy or contact us at the number provided for other payment options.

D. TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

☐ **Under penalties of perjury**, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

3. I am a U.S. citizen or other U.S. person (that is, an individual who is a **U.S. citizen** or **U.S. resident alien**, a partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, an estate [other than a foreign estate], or a domestic trust [as defined in Regulations section 301.7701-7]).

Certification instructions: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.Your signature at the bottom of this form certifies that you have read and attest to the information provided.

E. THE FOLLOWING DOCUMENTS ARE ATTACHED

☐ Certified Death Certificate

☐ Original Policy

☐ Assignment Documents

☐ Medical Authorization Form

☐ Accidental Death information (Section G)

☐ Medical History Information (Section H)

☐ Other _____

F. CLAIMANT STATEMENT AND SIGNATURE

☐ **Certificate of Lost Policy:** I certify that the life insurance policy identified has been lost or destroyed and, to the best of my knowledge, is not in anyone's possession. If the original should be found or come into my possession, I will return it to the Company, its successors or assignees. It is understood and agreed that the original policy shall become null and void.

I, the claimant, hereby make claim to the proceeds payable under the provisions of this policy and agree that all papers called for by the Company shall be part of this statement. My signature below also certifies, separately, that the information in Sections A - H is true and correct to the best of my information and belief, subject to penalties for perjury.

BENEFICIARY SIGNATURE _____ DATE _____

See IMPORTANT INFORMATION insert for additional information and instruction

G. ACCIDENTAL DEATH INFORMATION

PROVIDE THE FOLLOWING INFORMATION IF THE DEATH WAS ACCIDENTAL:

DATE OF ACCIDENT

LOCATION OF ACCIDENT

DESCRIPTION OF ACCIDENT

H. MEDICAL HISTORY INFORMATION

COMPLETE THE ENCLOSED MEDICAL AUTHORIZATION FORM AND SUBMIT WITH THE CLAIM.

PROVIDE THE FOLLOWING INFORMATION IF THE POLICY HAS BEEN ACTIVE FOR LESS THAN TWO (2) YEARS:

DATE DECEDENT FIRST COMPLAINED OR GAVE OTHER INDICATION OF FATAL ILLNESS

DATE DECEDENT FIRST CONSULTED A PHYSICIAN FOR THE FATAL ILLNESS

Name and address of the decedent's Primary Care Provider:

FIRST NAME LAST NAME SUFFIX

BUSINESS OR ENTITY NAME

ADDRESS 1

ADDRESS 2

CITY STATE ZIP

Provide the names and addresses of all other health care providers that treated the decedent during the past 2 years:
NOTE: PROVIDE ADDENDUM FOR ADDITIONAL HEALTH CARE PROVIDERS

FIRST NAME LAST NAME SUFFIX

BUSINESS OR ENTITY NAME

ADDRESS 1

ADDRESS 2

CITY STATE ZIP

DATE TREATED DISEASE OR CONDITION

Provide the names and addresses of all other health care providers that treated the decedent during the past 2 years:
NOTE: PROVIDE ADDENDUM FOR ADDITIONAL HEALTH CARE PROVIDERS

FIRST NAME | LAST NAME | SUFFIX

BUSINESS OR ENTITY NAME

ADDRESS 1

ADDRESS 2

CITY | STATE | ZIP

DATE TREATED | DISEASE OR CONDITION

FIRST NAME | LAST NAME | SUFFIX

BUSINESS OR ENTITY NAME

ADDRESS 1

ADDRESS 2

CITY | STATE | ZIP

DATE TREATED | DISEASE OR CONDITION

FIRST NAME | LAST NAME | SUFFIX

BUSINESS OR ENTITY NAME

ADDRESS 1

ADDRESS 2

CITY | STATE | ZIP

DATE TREATED | DISEASE OR CONDITION

Authorization to Obtain Medical Records

For Life Insurance - Pursuant to the HIPAA Privacy Rule

1. Insured party whose medical records will be obtained

Printed Name	Date of Birth	Social Security Number

Address	City	State	Zip Code

2. Disclosing Party

Any physician or other health care provider, hospital, clinic, medical facility, clinical lab, pharmacy, pharmacy benefit manager or pharmacy-related organization, insurance company or health plan, Social Security Administration, or the insured party's employer

3. Description of information authorized for release

Any information related to past, present or future health condition(s), medical care or treatment, which includes information about mental health, communicable disease, HIV/AIDS and substance abuse, but excludes psychotherapy notes

4. Purpose of this Authorization

To administer benefits under a policy or certificate of insurance

5. Duration of Authorization

Twenty-four (24) months from the date written below, unless I specify an earlier date here: _____

6. Receiving Party

CNO Services, LLC on behalf of one or more of the following insurance affiliates: Bankers Life and Casualty Company, Bankers Conseco Life Insurance Company *, Colonial Penn Life Insurance Company, Conseco Life Insurance Company, Washington National Insurance Company

*domiciled in and licensed in the State of New York