



# Trinity Life Insurance Company

## ADMINISTRATIVE OFFICE

PO BOX 5205 • FRANKFORT, KY 40602-5205

Phone: (866) 440-1357 • Fax: (502) 223-6575 (Claims Only)

### SECTION A - COMPLETE FOR ALL CLAIMS

|                                     |  |   |                          |             |   |               |        |               |                          |        |  |
|-------------------------------------|--|---|--------------------------|-------------|---|---------------|--------|---------------|--------------------------|--------|--|
| 1. DECEASED'S LAST NAME             |  |   | FIRST NAME               | MIDDLE NAME | 7A. POLICY(IES) WITH THIS COMPANY UNDER WHICH YOU CLAIM AN INTEREST |               |        |               |                          |        |  |
|                                     |  |   |                          |             | POLICY NUMBER   |               | AMOUNT | POLICY NUMBER |                          | AMOUNT |  |
| 2. DATE OF BIRTH                    |  | 3. SOURCE FROM WHICH DATE OF BIRTH OBTAINED<br><i>(Example: Birth Certificate, Drivers License or Family Bible)</i> |                          |             |   |               |        |               |                          |        |  |
| 4. DATE OF DEATH                    |  | 5. CAUSE OF DEATH   |                          |             |   |               |        |               |                          |        |  |
|                                     |  | 6. SOCIAL SECURITY No.:   |                          |             | 7B. POLICY PROCEEDS ASSIGNED TO:                                    |               |        |               |                          |        |  |
| 8A. CLAIMANT'S NAME:                |  |   |                          |             | 8B. CLAIMANT'S NAME:  |               |        |               |                          |        |  |
| DATE OF BIRTH                       |  | AGE   | RELATIONSHIP TO DECEASED |             |   | DATE OF BIRTH |        | AGE           | RELATIONSHIP TO DECEASED |        |  |
| 1 <sup>ST</sup> CLAIMANT'S ADDRESS: |  |   |                          |             | 2 <sup>ND</sup> CLAIMANT'S ADDRESS:                                 |               |        |               |                          |        |  |
|                                     |  |   |                          |             |   |               |        |               |                          |        |  |
| 1 <sup>ST</sup> CLAIMANT'S PHONE:   |  |   |                          |             | 2 <sup>ND</sup> CLAIMANT'S PHONE:                                   |               |        |               |                          |        |  |

### SECTION B - Complete fully if a claim is being submitted under any policy that was issued or reinstated within the two (2) years prior to the date of death. If not applicable, go to Section C.

|   |  |  |        |  |      |                                 |        |
|---|--|--|--------|--|------|---------------------------------|--------|
| 1. DATE DECEASED'S HEALTH WAS FIRST AFFECTED BY LAST ILLNESS:   |  | 2. DATE DECEASED FIRST CONSULTED A PHYSICIAN FOR LAST ILLNESS: |        | 3. DATE DECEASED LAST ATTENDED USUAL WORK: |      |                                 |        |
| 4. OCCUPATION AT DEATH  |  |  |        | 5. NAME OF LAST EMPLOYER                   |      |                                 |        |
| 6. LIST ALL PHYSICIANS/HOSPITALS WHERE TREATED LAST 5 YEARS PRIOR TO DATE OF DEATH. <i>(Please use a separate sheet of paper if additional space required.)</i> |  |  |        |  |      |                                 |        |
| NAME OF PHYSICIANS/HOSPITALS  |  | ADDRESS AND PHONE NUMBER                                       |        |  | DATE | DISEASE, DIAGNOSIS OR CONDITION |        |
|   |  |  |        |  |      |                                 |        |
|   |  |  |        |  |      |                                 |        |
|   |  |  |        |  |      |                                 |        |
| 7. IF DEATH WAS VIOLENT OR ACCIDENTAL, USE SEPARATE SHEET OF PAPER TO DESCRIBE CIRCUMSTANCES. <i>(Please attached newspaper account if available.)</i>          |  |  |        |  |      |                                 |        |
| 8. WHAT OTHER COMPANIES WAS THE DECEASED INSURED FOR LIFE INSURANCE? <i>(Please use a separate sheet of paper if additional space required.)</i>                |  |  |        |  |      |                                 |        |
| NAME OF COMPANY   |  | DATE OF ISSUE  | AMOUNT | NAME OF COMPANY                            |      | DATE OF ISSUE                   | AMOUNT |
|   |  |  |        |  |      |                                 |        |
|   |  |  |        |  |      |                                 |        |

### SECTION C - CERTIFICATION OF CLAIMANT

I/we hereby make claim to said insurance, declare that all answers as above recorded are complete and true, and agree that the furnishing of this and any supplemental forms by the Company, shall not constitute an admission by it that there are any insurance in force on the life in question, nore a waiver of any of its rights or defenses. I hereby certify and agree that I have read and understand the **IMPORTANT NOTICE** contained on the reverse side of (or attached to) this claim form.

|                      |                   |      |                   |
|----------------------|-------------------|------|-------------------|
| CLAIMANT'S SIGNATURE | SOCIAL SECURITY # | DATE | WITNESS SIGNATURE |
| CLAIMANT'S SIGNATURE | SOCIAL SECURITY # | DATE | WITNESS SIGNATURE |

*If you do not provide your social security number, we are required to withhold 28% of the taxable proceeds on all Life Insurance products and 10% of the proceeds on all Annuities.*

## INSTRUCTIONS FOR COMPLETING PROOFS OF DEATH

It is not necessary to employ any person, firm or corporation for collection of any claim under this policy. In addition to completing the CLAIMANT'S STATEMENT on the front of this form, please furnish:

- Official Death Certificate, certificate with raised seal.
- The Policy. If the policy(ies) is (are) lost or destroyed, you must so certify on a separate sheet of paper.
- Evidence of change of name of insured or beneficiary (if applicable).

If death was violent or accidental, consideration of such claim can be facilitated by furnishing a police report, newspaper account, autopsy report and coroner's verdict, in addition to the foregoing.

### INSTRUCTIONS FOR COMPLETING CLAIMANT'S STATEMENT

**Every question must be distinctly and fully answered.**

1. Complete Section A and C for all death claims. Complete Section B only if (1) any policy was issued within two years of the date of death or (2) any policy contains an Accidental Death Provision and there is a possibility that death was caused by accidental bodily injury. If Section B is completed, the AUTHORIZATION for release of medical and employment information must also be completed. The Company reserves the right to obtain further information should it be deemed necessary.
2. The form must be completed by the persons to whom the insurance is payable. If the amount payable is to be divided among several beneficiaries, a separate form for each will be furnished, or if desired, two beneficiaries may sign one statement. When two beneficiaries join in one statement, question 8a of Section A pertains to one of them and question 8b applies to the other. Both must sign the form.
3. If a claimant is a minor, the Claimant's Statement is to be completed by the minor's legally appointed guardian, a certificate of whose appointment and authority must be furnished. In such case, question 8a should show the minor's information, and question 8b should show the legal guardians' information. Both must sign the form, if possible.
4. When policy proceeds are payable to "children" or others of a class, no names being specified, a sworn statement must be furnished, giving names and dates of birth of each; and if any died, the sworn statement must give the date and place of death and must state whether they died without a will, unmarried and without children.
5. When policy proceeds are payable to the estate of the insured, this statement must be made by an executor or administrator, a certificate of whose appointment and authority must be furnished.
6. When a policy has been assigned, this statement must be made by the assignee who must submit the original assignment. If the assignment of the policy is collateral in intent, regardless of whether absolute in form, the statement must be completed jointly by the Beneficiary showing information in question 8a and assignee information in question 8b. A statement of the amount claimed by the assignee, assented to by the beneficiary, must be furnished if separate checks are desired.
7. When policy proceeds are payable to someone who dies before the insured, a certified death certificate issued by the State Bureau of Vital Statistics must be furnished, giving the place and date of death of the deceased person. This requirement may be disregarded when the Company has received a prior claim on such person.
8. When policy proceeds are payable to a corporation or firm, this statement must be made by a duly qualified officer who has the power and right to make such claim in the name of the corporation or firm.

**IMPORTANT NOTICE: This is part of the claim form. Review the applicable fraud notice.**

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.

**The laws of some states require us to furnish you with the following notice:**

**Arizona:** "For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent statement 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."

**Colorado:** "It is unlawful to unknowingly 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 with regards to a settlement or award payable from insurance proceeds will be reported to the Colorado Division of Insurance within the department of regulatory agencies."

**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."

**Idaho:** "Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony."

**Indiana:** "Any 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."

**Kentucky:** "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."

**Minnesota:** "Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

**Ohio:** "Any person who, with intent to defraud or knowing that he/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."

**Oklahoma:** " **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

**Oregon:** "Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law."

**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.

**Texas:** Any person who knowingly presents a 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.

**Virginia:** "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"



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## HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize any health plan, physician, health care professional, hospital, Veterans Administration, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, insurance company, insurance support organization such as MIB), or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (collectively, "My Providers") to disclose my entire medical record, medication history, and any other protected health information concerning me to **Trinity Life Insurance Company, or its designee,**

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This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STDs.) This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, 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 my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that **Trinity Life Insurance 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 **Trinity Life Insurance Company.**

This authorization shall remain in force for 24 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 **Trinity Life Insurance Company**, P.O. Box 5205, Frankfort, KY 40602, Attn: General Counsel. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization or to the extent that **Trinity 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 disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal rules governing privacy and confidentiality of health information. However, **Trinity Life Insurance Company** will protect the privacy of health information in accordance with other applicable state and federal privacy laws and their own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, **Trinity Life Insurance Company** may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that I am entitled to a copy of this signed authorization.

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Signature of Personal Representative

Date

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Description of Personal Representative's Authority or Relationship to Patient  
(For death claims, please attach copy of appointment of executor of estate.)