



Transamerica Life Insurance Company
 Transamerica Financial Life Insurance Company
 P.O. Box 869094 Plano, TX 75086-9094
 Phone: 855-244-8318
 Fax: 855-604-5205

**Death Claim Form
 SELF-ADMIN**

Decedent's Information

1. Name in Full		2. Social Security No.		3. Policy No.	
4. Date of Birth	5. Street Address		6. City	7. State	8. Zip Code
9. Employer's Name					
10. Street Address			11. City	12. State	13. Zip Code
14. Date Last Worked		15. Occupation at Death			
16. Date of Death	17. Place of Death		18. Cause of Death		

Claimant's Information

1. Name in Full		2. Social Security No.		3. Date of Birth	
4. Daytime Phone Number			5. Evening Phone Number		
6. Email address:					
7. Are you subject to backup withholding? <input type="checkbox"/> Yes <input type="checkbox"/> No (see instruction # 11 for more information on taxes) I certify that this is my correct tax reporting number, and that I am not subject to backup withholding.					
Signature _____			Date _____		
This claimant made claim to the insurance and agrees that by furnishing this form, the Company does not affirm that any insurance was in force on the life of the deceased and does not waive any of its rights or defenses.					
Signed in (City/State) _____ This _____ Day of (Month/Year) _____ .					
Signature _____			Relationship to deceased _____		
Mailing Address		City		State	Zip code
Street Address		City		State	Zip Code

The information above is true and correct to the best of my knowledge.

 Claimant's Signature Date



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Employer's/Business Entity's Statement			
1. Decedent's Name in Full	2. Decedent's Age	3. Employee's/Insured Person's Name	4. Employee's/Insured Person's Social Security No.
5. Name of Company	6. Group Policy No.	7. Employee/Insured Person was <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	8. Employee's/ Insured Person's annual salary as of the date of loss
9. Date Insured (employee/insured person)	10. Date Insured (dependent)	11. Date of Hire	12. Last date Employee/Insured person actively worked
13. Employee's/Insured Person's status as of last date worked: <input type="checkbox"/> Active <input type="checkbox"/> Vacation <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Laid Off <input type="checkbox"/> Terminated <input type="checkbox"/> Retired If other than Active, Please explain: _____			14. Date employee/insured person returned to work:
15. Did injury occur while at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	16. If "Yes", give date of injury and details		
17. Amount of Insurance	18. Amount of Claim	19. Was premium paid and insurance in force at time of loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Signed in (City/State) _____ This _____ Day of (Month/Year) _____ .			
_____ Printed Name of Authorized Representative		_____ Signature of Authorized Representative	_____ Official Title
Phone Number _____		Fax Number _____	

REQUIRED FRAUD WARNING STATEMENTS

Claimants are required to acknowledge receipt of fraud warnings. Please refer to the fraud warning statement for your state as indicated below. Sign, date, and return with claim documents.

<p>FOR RESIDENTS OF ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.</p>	<p>FOR RESIDENTS OF NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided by RSA 638:20.</p>
<p>Claimant's signature _____ Date _____</p>	<p>Claimant's signature _____ Date _____</p>
<p>FOR RESIDENTS OF 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.</p>	<p>FOR RESIDENTS OF 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.</p>
<p>Claimant's signature _____ Date _____</p>	<p>Claimant's signature _____ Date _____</p>
<p>FOR RESIDENTS OF CALIFORNIA: For your protection California law requires the following to appear on this form. 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.</p>	<p>FOR RESIDENTS OF NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.</p>
<p>Claimant's signature _____ Date _____</p>	<p>Claimant's signature _____ Date _____</p>
<p>FOR RESIDENTS OF COLORADO: 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 the insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.</p>	<p>FOR RESIDENTS OF OHIO: 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.</p>
<p>Claimant's signature _____ Date _____</p>	<p>Claimant's signature _____ Date _____</p>
<p>FOR RESIDENTS OF DELAWARE, IDAHO, INDIANA or OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.</p>	<p>FOR RESIDENTS OF OREGON: Any person who knowingly and with intent to defraud an insurance company files an application for insurance or statement of claim containing any materially false information may be guilty of insurance fraud. To deny a claim on the basis of misstatements, misrepresentations, omissions or concealments, the mis-information must be material to the content of the policy, the insurer relied upon the mis-information and the information was either material to the risk assumed by the insurer or provided fraudulently. Misstatements, misrepresentations, omissions or concealments are not fraudulent unless they are made with the intent to knowingly defraud.</p>
<p>Claimant's signature _____ Date _____</p>	<p>Claimant's signature _____ Date _____</p>
<p>FOR RESIDENTS OF DISTRICT OF COLUMBIA or LOUISIANA: 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.</p>	<p>FOR RESIDENTS OF 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 a person to criminal and civil penalties.</p>
<p>Claimant's signature _____ Date _____</p>	<p>Claimant's signature _____ Date _____</p>
<p>FOR RESIDENTS OF 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.</p>	<p>FOR RESIDENTS OF PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than \$5,000 and not more than \$10,000, or a fixed term of imprisonment for 3 years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of 5 years, if extenuating circumstances are present, it may be reduced to a minimum of 2 years.</p>
<p>Claimant's signature _____ Date _____</p>	<p>Claimant's signature _____ Date _____</p>
<p>FOR RESIDENTS OF MARYLAND, RHODE ISLAND, TEXAS or WEST VIRGINIA: 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.</p>	<p>FOR RESIDENTS OF VIRGINIA: 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 the state law.</p>
<p>Claimant's signature _____ Date _____</p>	<p>Claimant's signature _____ Date _____</p>
<p>FOR RESIDENTS OF MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.</p>	<p>FOR RESIDENTS OF ALL OTHER STATES AND TERRITORIES: Any person who knowingly, and with intent to injure, defraud or deceive 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.</p>
<p>Claimant's signature _____ Date _____</p>	<p>Claimant's signature _____ Date _____</p>



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AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of health information about the Insured as described below and revoke any previous restrictions concerning access to such information:

- Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any physician, medical practitioner, hospital, clinic, pharmacy, long-term care facility, nursing home, assisted living facility, home health care entity, medical or medically-related facility, laboratory, and insurance company (including the Company selected above), or other organization, institution or person having records or knowledge of the Insured's health.
- Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** the Company noted above, its affiliates, its reinsurers, their agents or other representatives, and business associates.
- Description of the information that may be used or disclosed:** This authorization relates to the release of any medical records necessary to evaluate and determine the Insured's eligibility for benefits, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse information, or information regarding AIDS. **Exception: psychotherapy notes require a separate signed authorization.**
- The information will be used or disclosed only for the following purpose(s):** The requested information will be used for any claim processing purposes, including but not limited to determining the Insured's benefit eligibility and making benefit determinations.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that the Insured's eligibility for benefits may be affected if I refuse to sign this form. In that case, the Company may not be able to determine if the Insured qualifies for benefits.
- I understand that the Insured has a right to receive the HIPAA Notice of Health Information Privacy Practices that explains the Company's privacy practices (not applicable to life, accident or disability insurance policies).
- I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment or health care operations.
- This authorization shall be valid for as long as claims continue under the policy, and I understand I am entitled to a signed copy.
- A copy of this authorization will be considered as valid as the original.
- I acknowledge that I have received a copy of this authorization.

Patient/Insured's Name/Signature _____ Date _____

Patient/Insured's SSN _____ Patient/Insured's Date of Birth _____ Patient/Insured's Phone No. _____

Patient/Insured's Address _____

Personal Representative's (if any) Name/Signature: _____ Personal Representative's Phone No. _____

Personal Representative's (if any) Address _____

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

Policy or Contract Number _____

Claimant should retain a copy of this signed document for their records