



Transamerica Premier Life Insurance Company
4333 Edgewood Road NE
Cedar Rapids, Iowa 52499
1-800-638-3080 / Fax: 410-385-5971

Submit This Completed Form With a Death Certificate for The Deceased Insured and the Original Policies

Section A- Deceased's Information

Section B- Your Information

Policy Numbers
Deceased's Name
Any Previous Name
Social Security No.
Deceased's Date of Death
Deceased's Date of Birth
Deceased's Address

Name of Claimant
Your Social Security No.
Are you a US Citizen/Resident Alien? YES NO
If no, of what Country are you a citizen?
Mailing Address
Daytime Telephone
Email Address
Relationship to Deceased
Date of Birth Age

I certify under penalties of perjury that I am a US Citizen or resident alien, that the number shown on this form is my correct taxpayer ID, and that I am not subject to back-up withholding. I attest that if an insurance policy has not been submitted with this claim, the policy has been lost or destroyed. I have read the applicable fraud warning statement which accompanied this form.

Signature Date

Section C- Information We Need From You to Process Your Claim

Name of Funeral Home handling burial
Funeral Home Address
Funeral Home Telephone Number Funeral Home Tax ID Number

Louisiana Residents Only - Will the proceeds be used to fund a preneed funeral contract? YES NO
If yes, a certified death certificate is required

If you did not attach a Certified Death Certificate, circle the manner of death below:

NATURAL ACCIDENTAL HOMICIDE SUICIDE PENDING INVESTIGATION

Section D- Deceased's Medical Providers

Provide the Name, Address, and Phone Number of all medical providers who treated the deceased during the last five years.

Provider's Name Address Phone Number

MAIL OR FAX ALL CLAIM DOCUMENTS TO THE ADDRESS OR FAX NUMBER ABOVE



TRANSAMERICA PREMIER LIFE INSURANCE COMPANY

4333 Edgewood Road NE
Cedar Rapids, Iowa 52499

HIPAA Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule

A copy of this authorization will be considered as valid as the original

Note to claimant/personal representative: This authorization must be signed for us to receive medical records under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Although we may not need to obtain medical records to process your claim, we must obtain this form to avoid possible delays if medical information is needed.

I authorize all physicians, medical practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, long term care facilities (including assisted living facilities), home health care entities and other medical care institutions, medically related facilities, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders and benefit plan administrators, state and federal governmental agencies (including law enforcement agencies), Social Security Administration, Internal Revenue Service and Veteran Administration facilities, coroners, medical examiners and any other person or entity that has any health information relating to the insured/patient named below (collectively, the "Providers") to disclose the **entire medical record** and any other protected health information concerning the insured/patient to the company(ies) referenced at the top of this authorization (the "Companies"), their affiliates and reinsurers, and any business associate, agent, employee, representative, investigator, benefit plan administrator, consumer reporting agency (including MIB, Inc. formerly known as the Medical Information Bureau) or independent claim administrator acting on behalf of any of the Companies. This authorization includes release of any oral, written, or electronic information, records, documents, or knowledge concerning any medical care, medical advice, diagnosis, treatment or supplies, including psychiatric or mental health records (excluding psychotherapy notes), prescription drug information, substance abuse records, medical records, medical notes, and medical recordings. This also includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, to the extent permitted by state law.

By my signature below, I acknowledge that any agreements the insured/patient has made to restrict his or her protected health information do not apply to this authorization and I instruct the Providers to release and disclose the **entire medical record and any other protected health information as noted above** without restriction.

The information disclosed will be used for claims processing, including but not limited to evaluating contestability, eligibility determination, and/or benefit determinations.

This authorization shall remain in force for 24 months, or in the case of long term care or disability claims for the duration of the claims under such policy, following the date of my signature below. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Companies at Attention: Consumer Affairs Department, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499. Alternatively, I may revoke this authorization by sending a written revocation directly to the Providers. 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 the Companies have 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 regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Companies will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and their own privacy policies. I understand that I have a right to receive the Notice of Health Information Privacy Practices upon request.

I understand that Providers that are subject to the HIPAA Privacy Rule (not including the Companies) may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I do understand that if I refuse to sign this authorization to release the **entire medical record** of the insured/patient, the Companies may not be able to proceed with claims or eligibility processing or make any benefit payments. I acknowledge that (1) if I am signing on behalf of the insured/patient, I am legally permitted to do so as the personal representative of the insured/patient, and (2) I have received a copy of this authorization.

Name of insured/patient (please print)

Date of birth

Signature of Insured/Patient or Personal Representative of the Insured/Patient

Date

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

MM4441191

Policy or Contract Number



SURVIVOR'S STATEMENT

Insured's Name: _____ SS# _____

Insured's Date of Death _____ Date of Birth _____

Policy Number(s): _____

Your answers to the questions below will direct payment of the claim proceeds in succession as follows: We will pay the Estate of the Insured unless no Estate is established; then, we will pay the Funeral Home to satisfy the Insured's final expense unless paid; and then, we will reimburse the person who paid the Insured's funeral expenses.

1. **Has an estate been opened for the above Insured?** Yes No
If yes, provide the Executor's Information below and attach a copy of Letters of Administration.
Executor's Name: _____ Telephone #: _____
Executor's Address: _____

2. **Are there outstanding funeral expenses related to the Insured?** Yes No
If yes, any outstanding funeral expenses will be confirmed and paid to the Funeral Home below;
LA Residents - Will the policy proceeds be used to fund a preneed funeral contract? Yes.
If yes, a certified death certificate is required.
Funeral Home: _____ Tax ID#: _____
Address: _____
Telephone: _____

3. **If you have answered 'no' to Questions 1 and 2 above, benefits will be paid to the person who paid for the Insured's funeral expenses. ATTACH A RECEIPT SHOWING PROOF OF PAYMENT IN FULL OF THE INSURED'S FUNERAL EXPENSE BY THE PERSON PROVIDED BELOW. Any benefits exceeding reimbursement of the funeral expenses will be divided among the heirs in order of intestate succession.**
Name _____ Social Security # _____
Address _____
Telephone _____

I swear the following information is true and correct. I certify that all living relatives or persons entitled to inherit under the Estate of the above Insured are listed below and that if the policy contract was not submitted with this Form or the Claim Form the policy contract was lost or destroyed. Furthermore, I release Transamerica Premier Life Insurance Company from any cost, liability or harm relating to payment of any claim made pursuant to this Survivor's Statement. Also, each person who signs this Form is jointly and severally liable and agrees to indemnify and hold harmless Transamerica Premier Life Insurance Company from any damage, cost or liability that results from payment of a claim pursuant to this Survivor's Statement. I have read the applicable fraud warning statement which accompanied this form.

I certify under penalty of perjury that I am a US Citizen or resident alien, that the number shown on this form is my correct taxpayer ID, and that I am not subject to back-up withholding.

Name: _____
SSN: _____ Age _____
Relationship: _____
Address: _____
Phone: _____
Email Address _____
Of what Country are you a citizen? _____

Name: _____
SSN: _____ Age _____
Relationship: _____
Address: _____
Phone: _____
Email Address _____
Of what Country are you a citizen? _____

Signature: _____ **Date:** _____
Name: _____
SSN: _____ Age _____
Relationship: _____
Address: _____

Signature: _____ **Date:** _____
Name: _____
SSN: _____ Age _____
Relationship: _____
Address: _____

Phone: _____
Email Address _____
Of what Country are you a citizen? _____

Phone: _____
Email Address _____
Of what Country are you a citizen? _____

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

*****Mail or Fax all claim documents to the address or fax number above*****

REQUEST FOR VERIFICATION OF POLICY PROCEEDS

FAX# 410-385-5971

NOTICE - Transamerica's receipt of this form shall not be construed as our acceptance and recognition of an assignment on the policies provided below.

FAX this information to:

Funeral Home Name Chase National Corporation

Address 105 S. Commercial St., Suite 2

Harrisburg, IL 62946

Phone# 618-252-2824

Fax # 618-252-2226

618-252-2226

Deceased's Name _____

Date of Death _____

Cause of Death Natural () Accident () Other ()

Date of Birth _____

Social Security Number _____

Policy Number

Issuing Company

I Authorize Transamerica to furnish to the above named Funeral Home any information that I would be entitled to receive about the policies provided on this form insuring the deceased person named above, including, but not limited to, the amount of the death benefit, other Beneficiaries if any and other information requested by the Funeral Home relating to the insurance policy(ies); I am authorized to sign this form, and hereby release Transamerica from any liability it may incur by releasing this information.

Signature of Beneficiary/Executor _____

Date: _____