Transamerica Premier Life Insurance Company

Administrative Office
Claims Department
Valley Forge, PA 19493

CLAIM FORM

DECEASED INFORMATION		
Name: (Last, First, Middle)	Was the deceased known by any other name? NO ☐ YES ☐ If yes, list other names:	
Address:	Date of Birth:	Date of Death:
City/State/Zip:	Cause of Death:	
Policy/Certificate Number(s):	Social Security #:	Driver's License #:

CLAIMANT/BENEFICIARY INFORMATION		
Name:	Relationship to Insured:	Date of Birth:
Address:	Daytime Phone:	
City, State, Zip:	Social Security Number:	
Your Citizenship: (_____) U.S. (_____) Other (If Other, list name of country)		

DOES THE DECEASED HAVE OTHER INSURANCE?		
Insurance Company:	Benefit Amount:	Policy/Certificate #:

MEDICAL HISTORY – LIST MEDICAL TREATMENT IN THE LAST 5 YEARS			
Name of Hospital or Physician:	Condition / Dates of Service:	Address:	Phone:

CLAIM DETAILS (ONLY NEED TO COMPLETE IF FILING FOR ACCIDENTAL DEATH BENEFITS)

How, where did accident happen? What injuries were received? *(Describe fully)* Please list names/addresses/phone numbers of all doctors and hospitals that provided treatment for this incident:

Names and addresses of all eyewitnesses to accident:

If Police Report is not attached, please give name, address & phone number of Police Department that investigated this case:

Name of Investigating Officer: Phone: ( )

If Autopsy/Inquest is not attached, please list name, address & phone number of the organization performing Autopsy/Inquest:

Name, address and phone number of Pharmacy used by deceased:

AUTHORIZATION (Signature required)

I, the undersigned, declare that to the best of my knowledge, all answers recorded are complete and true. I have not been notified by the Internal Revenue Service that I am subject to a backup withholding order on interest or dividends.

I, the undersigned, authorize any hospital, physician or insurance company, employer or association to furnish Transamerica Premier Life Insurance Company and their representatives any and all information with respect to any illness or injury, medical history, consultation, prescription, or treatment and copies of all hospital or medical records (or Photostats thereof) of the deceased named above, to determine eligibility for benefits under an existing policy/certificate. This authorization is valid for the duration of the claim and a photo static copy shall be considered as valid as the original.

_____ _____

Authorized Signature Date