SOUTHERN NATIONAL
LIFE INSURANCE COMPANY, INC.

A subsidiary of Blue Cross and Blue Shield of Louisiana,
independent licensees of the Blue Cross and Blue Shield Association.

Group Life, Accidental Death, and Voluntary Life Claim Form Employee or Dependent

IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

To the Employer and Employee/Beneficiary, as applicable.
We know this is a difficult time, and we want to assist you in filing your claim as quickly as possible. Please read these important instructions regarding completion of these forms.

The information below constitutes a complete claim filed with Southern National Life Insurance Company, Inc. for purposes of claiming Basic, Accidental Death, Voluntary, and Dependent coverage.

Part I - Employer's Statement (needed for both Life or Accidental Death claims)

☐ Form is to be completed in its entirety and signed by the Official Representative of the Employer/Plan. **A CERTIFIED DEATH CERTIFICATE STATING CAUSE AND MANNER OF DEATH MUST BE ATTACHED TO THIS FORM.**

☐ Proof of salary as defined in the Policy (attach W2 or commissions, if applicable)

☐ Submission of claims on any group voluntary or contributory Life plans, including Dependent coverage.

☐ All claims must be submitted, along with the beneficiary designation forms on file with the Employer/Plan, if any. If none on file, the Employer/Plan shall certify to that fact on the claim form.

Part II - Beneficiary Statement (needed for both Life and Accidental Death claims)

☐ If more than one beneficiary, each beneficiary can either sign and date one form, or each can complete separate forms, showing their current address, date of birth and Social Security Number.

☐ **If claiming Accidental Death please furnish, if available, police or motor vehicle Accident/Incident reports, autopsy/ toxicology or other pertinent information regarding the claim.**

Miscellaneous - All Claims

☐ If the claim proceeds are payable to an Estate, Executors or Administrators of the Estate, Part II must be completed by an Executor or Administrator. An official certificate of such person's legal appointment and qualification must be attached to this form.

☐ If any designated beneficiary is a minor, Part II must be completed by a custodian or guardian. An official certificate of the guardian's legal appointment and qualification of the minor's **estate or property** must be attached to this form, if applicable.

☐ Foreign Death - Include both the Official Death Certificate and the Death of American Citizen Abroad form.

Mail or fax completed forms to: Southern National Life Insurance Company, Inc.
P.O. Box 98044
Baton Rouge, LA 70898-9044
FAX: (225) 297-2665

Release of claim forms is not an admission of coverage under a policy for an employer, group or organization.

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Proof of Death Form - Employee or Dependent

Part I - Employer's Statement - To be completed in full for all claims

Group Policy Numbers: Life/AD&D _____ Voluntary/AD&D _____				Member ID Number
Name of Insured/Participant				Employer
Insured's Mailing Address (Street, City, State & Zip Code)				
Social Security Number	Date of Birth	Date of Death	Date of Hire	Was employee actively working full time? ❑ Yes ❑ No
Date last physically at work	Reason employee did not return to work			
Effective date of employee's insurance	Have premiums been paid to date? ❑ Yes ❑ No	Occupation	Classification	
Is a Beneficiary Designation Card on file? ❑ Yes ❑ No If "Yes," a copy must be submitted.			❑ FMLA (provide approval form)	

Amount of Insurance Being Claimed for Employee or Amount in Force for Employee if Dependent Claim

Basic Life $ _____ Voluntary Life $ _____	(Employee's earning as defined in the policy. Attached W-2 if applicable) Rate of earnings used to calculate benefit amount: _____ ❑ Hourly ❑ Weekly ❑ Monthly ❑ Annually
Complete below only if claim is due to an accident (Employee only)	
AD&D Basic $ _____ AD&D Voluntary $ _____ AD&D High Level $ _____	Regular hours scheduled to work (if applicable) _____ Effective date of above reported earnings _____
Coverage amounts claimed include age reduction? ❑ Yes ❑ No	Do the earnings include commissions or bonuses? ❑ Yes ❑ No
Date insurance was discontinued or not in force? _____	Has a claim for Long Term disability ever been approved? ❑ Yes ❑ No
Was application for conversion completed? ❑ Yes ❑ No	Has a claim for Waiver of Premium ever been approved? ❑ Yes ❑ No
Was an Accelerated Death Benefit or Waiver of Premium claim ever approved by the prior carrier? ❑ Yes ❑ No	

Note: Changes in amounts of coverage, or increases in coverage, may not apply if the employee was absent from work due to illness or injury on the effective date. Changes in amounts of coverage and increases are deferred untill employee returns to active full-time work. If the employee elected increases in coverage during the past two years, the amount being claimed reflects the increase, attach copies of the election forms.

Dependent Information - ONLY COMPLETE FOR DEPENDENT CLAIM

Full Name of Deceased Dependent (Last, First, Middle Initial)	Dependent's Social Security Number	Date of Birth	Date of Death
Relationship to Employee	Last Residence (Number, Street, City or Town, Zip code)	Have premiums been paid to date for this dependent? ❑ Yes ❑ No	
Was the dependent over age 26? ❑ Yes ❑ No			

Amount of Insurance Being Claimed for Dependent

Dependent Life $_____ Voluntary Dependent Life $_____

Employer Certification: I hereby certify that the information provided on the Employer Statement is true and complete according to the record of the Employer. I agree that this information is subject to audit by Southern National Life Insurance Company, Inc. and/or its representative.

Employer _____ Address _____

Signature _____ Date _____ Authorized Representative (Please print) _____

( ) _____ _____ ( ) _____

Telephone Number Email Address Facsimile Number

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PART II - Beneficiary's Statement

Name of Deceased ____________________ **Policy Number(s)** ____________________

Medical Release Authorization

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates, or information concerning the deceased or injured's occupation, finances and health including protected health information, individually identifiable health information, summary health information, psychotherapy notes, mental health, HIV, and alcohol/drug records to release all such records in their entirety to Southern National Life Insurance Company, Inc. and any affiliate of this company (collectively and severally, the "Company") for the purpose of processing my claim. I understand that I may receive a copy of this authorization, and that this authorization is valid for the entire duration of this claim, and that I may revoke this authorization at any time by sending a request in writing to the Company. I understand that it may be necessary for the Company to provide such information or summaries thereof to the employer, regulatory state agency, or Workers' Compensation carrier or other entities who may not be required to protect it under Federal privacy rules. I understand that if I do not provide this authorization, Company may not be able to process my claim.

Beneficiary Name (print)		Date of Birth	Relationship
Complete Mailing Address (Number & Street)		Social Security Number or Estate/Trust Tax ID	
City, State & Zip Code		Telephone Number Day ( ) Evening ( )	
Signature X	Date	Email Address	

Beneficiary Name (print)		Date of Birth	Relationship
Complete Mailing Address (Number & Street)		Social Security Number or Estate/Trust Tax ID	
City, State & Zip Code		Telephone Number Day ( ) Evening ( )	
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