Member • Erie Insurance Group
Home Office • 100 Erie Insurance Place • Erie, Pennsylvania 16530 • (814) 870-2000 • Toll Free 1.800.458.0811

CLAIMANT'S STATEMENT

The following documentation, in addition to this completed claimant's statement, is necessary in order for Erie Family Life Insurance Company to process a death claim:

A. DEATH CERTIFICATE

A certified copy of the death certificate should be obtained and forwarded to the Home Office. Other documentation, such as notice from local newspaper, etc., particularly in the case of accidental death or possible suicide, is desirable but not required. Such additional data will NOT be accepted as a substitute for the death certificate.

Should any beneficiary be deceased, a death certificate of that beneficiary should also be furnished.

B. ORIGINAL POLICY OR POLICIES

The original policy should be secured and forwarded with the Claimant's Statement and the death certificate. If the original policy cannot be located, it should be so indicated on the Claimant's Statement.

INSTRUCTIONS FOR COMPLETING THE CLAIMANT'S STATEMENT (Mailing Instructions for Proceeds, Part I and III should be completed for all claims)	
PART I	This form must be executed before a WITNESS by the person or persons to whom the insurance is payable. This form accommodates up to four claimants. Please use an additional form if there are more than four claimants. If the policy is payable to the ESTATE or EXECUTORS or ADMINISTRATORS of the insured, the statement should be executed by the executor or administrator, a certificate of whose appointment and qualifications must be furnished. If the policy is payable to a MINOR or a MENTALLY INCOMPETENT PERSON, a statement should be executed by a GUARDIAN. An official certificate of appointment and qualifications must be furnished. If the policy has been ASSIGNED ABSOLUTELY both in form and in fact, the statement should be executed by the ASSIGNEE. If the policy has been COLLATERALLY ASSIGNED, the statement should be executed by both the CLAIMANT(S) and ASSIGNEE and a statement agreed to by both parties should be furnished showing the extent of the assignee's interest in the policy.
PART II	Part II of this form and the AUTHORIZATION should be completed in all claims for Accidental Death Benefit or policies in force or reinstated within two years or less at the time of the insured's death.
PART III	Part III of this form be must signed by all claimant(s) making a claim. Each claimant's signature must be witnessed.

NOTE: AUTHORIZATION NEEDS TO BE COMPLETED ONLY IF THE DEATH OF THE INSURED OCCURRED WITHIN THE 2-YEAR CONTESTABLE OR IF A CLAIM IS BEING MADE FOR AN ACCIDENTAL DEATH BENEFIT.

MAILING INSTRUCTIONS FOR DEATH CLAIM PROCEEDS

☐ Return proceeds to Agent for delivery

☐ Mail proceeds directly to beneficiary

☐ Other ____

Authorization for Release of Health-Related Information
To Erie Family Life Insurance Company

____ ____ / ____ / _____
Name of Deceased Insured/Former Patient (please print) Date of birth

____ / ____ / _____
Date of death

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to the above-named deceased individual or on his/her behalf within the past 10 years ("Providers") to disclose the entire medical record and any other protected health information concerning the above-referenced individual to the Erie Family Life Insurance Company and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

This protected health information is to be disclosed under this Authorization so that Erie Family Life may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage the above-named deceased individual has or has applied for with Erie Family Life Insurance Company.

This authorization shall remain in force for 6 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 Erie Family Life Insurance Company at 100 Erie Insurance Place, Erie, PA 16530, Attention: Life Claims Department. 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 Erie Family 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 that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical record, Erie Family Life Insurance Company may not be able to process this claim, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

____
Signature of Deceased's Personal Legal Representative Date

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

(Before completing, read instructions on first page.)

By furnishing forms and investigating the claim, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

(PLEASE TYPE OR PRINT)

PART I—DECEASED AND CLAIMANT INFORMATION—COMPLETE THIS SECTION FOR ALL CLAIMS.

Policies of this Company under which claim is being made:

POLICY NUMBER(S)	POLICY ISSUE DATE	AMOUNT OF INSURANCE	PLEASE INDICATE IF POLICY IS:
______	______	______	☐ Attached ☐ Lost
______	______	______	☐ Attached ☐ Lost
______	______	______	☐ Attached ☐ Lost

1. a. Deceased's name in full ______ b. Please list any other name the Insured may have been known by such as maiden name, nickname or alias: ______
   c. Residence address ______
   d. Occupation at death ______ e. Date last worked ______
   f. Social Security No. ______
   g. Deceased's marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

2. a. Date of BIRTH of deceased ______ Place of birth ______
   b. Where was date of birth obtained? (Birth or Baptismal record should be consulted if possible.) ______

3. a. Date of DEATH ______ d. Place of death ______
   b. Cause of death ______
   c. Duration of illness ______

CLAIMANT INFORMATION:

a. Claimant I Name ______
b. Residence Address ______
c. Phone No.: Home ______ d. Work ______
e. Taxpayer Identification No. (Social Security Number): ______
f. Relationship to Insured ______ g. Claimant's date of birth ______

a. Claimant II Name ______
b. Residence Address ______
c. Phone No.: Home ______ d. Work ______
e. Taxpayer Identification No. (Social Security Number): ______
f. Relationship to Insured ______ g. Claimant's date of birth ______

a. Claimant III Name ______
b. Residence Address ______
c. Phone No.: Home ______ d. Work ______
e. Taxpayer Identification No. (Social Security Number): ______
f. Relationship to Insured ______ g. Claimant's date of birth ______

a. Claimant IV Name ______
b. Residence Address ______
c. Phone No.: Home ______ d. Work ______
e. Taxpayer Identification No. (Social Security Number): ______
f. Relationship to Insured ______ g. Claimant's date of birth ______

PART II — PHYSICIAN AND HOSPITAL INFORMATION
THIS SECTION NEEDS ONLY TO BE COMPLETED IF THE DEATH OF THE INSURED OCCURRED WITHIN THE 2-YEAR CONTESTABLE PERIOD ON ANY OF THE POLICIES LISTED IN PART I OR IF A CLAIM IS BEING MADE FOR AN ACCIDENTAL DEATH BENEFIT.

5. Please complete the following:

a. List the name and address of any physician(s) the insured has been treated by within the last three years.

PHYSICIAN'S NAME	ADDRESS

b. List the name and address of any hospitals or institutions the insured has been treated at within the last three years.

HOSPITAL NAME	ADDRESS

c. Provide the information concerning other life and/or accident insurance on the deceased.

NAME OF INSURANCE COMPANY	DATE OF POLICY	AMOUNT OF INSURANCE

6. Please indicate the manner of death as shown on the death certificate

☐ Natural Causes ☐ Homicide
☐ Accident ☐ Undetermined
☐ Suicide ☐ Pending

* If beneficiary disagrees with the manner of death stated on the death certificate, please indicate below and provide an explanation:

PART III—CLAIMANT(S) SIGNATURE(S)—COMPLETE THIS SECTION FOR ALL CLAIMS.

I declare that I have read and understood all the statements shown on this form, that they are true and complete to the best of my knowledge and correctly recorded.

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.

WITNESS	CLAIMANT I SIGNATURE	DATE
WITNESS	CLAIMANT II SIGNATURE	DATE
WITNESS	CLAIMANT III SIGNATURE	DATE
WITNESS	CLAIMANT IV SIGNATURE	DATE