Phone: (877) 442-4207 | Fax: (855) 645-8242

EMPLOYER INFORMATION FOR SUBMITTING A LIFE CLAIM



DearbornCares^{5M}

Advance Payment of the Life Insurance Benefit

DearbornCares provides an advance payment of up to \$10,000 per beneficiary in 48 hours* to help cover their immediate expenses, such as funeral costs and medical bills.

- ▲ Pays up to \$10,000 per beneficiary of Employer-Paid Basic Life insurance claims
- ▲ Applies to claims with 1, 2 or 3 named beneficiaries
- ▲ Available for covered employees and retirees

The Death Certificate is NOT REQUIRED for the advance payment.

Please complete Part 1 of the Life Insurance Claim Form in its entirety and include the Beneficiary Designation. Any remaining information in the checklist below must be submitted to us in order to complete the claim and receive the full payment.

*Pays up to \$10,000 per beneficiary (to max. of 3 beneficiaries) of Employer-Paid Basic Life insurance claims in 48 hours of confirming eligibility for DearbornCares. TPA Groups are not eligible for the DearbornCares program. This information is only a product highlight. DearbornCares has exclusions and limitations.

Em	ployer Checklist for Submitting a Life Claim:			
	employer/administrator must complete the claim form as indicated and send atta will advise you if further documentation is necessary to complete the claim proce		s mentioned below.	
Plea	se submit the following documentation: Life Claim Form		Accidental Death Benefits, vide the following:	
	Part 1 – Completed by the Employer/Administrator Part 2 – Completed by the Beneficiary(ies)		Official, completed police report	
_	Part 3 – Authorization for Release of Information to be completed by a beneficiary		Proof of seat belt/airbag use, if applicable	
Ц	Enrollment Form, including any beneficiary changes (original, photocopy or screen print)		Newspaper clipping(s) of	
	Certified copy of the Official Death Certificate (for total coverages over \$100,000, we require an original Certified Death Certificate with a seal)		accident, if applicable Coroner's report, findings	
	Payroll Records verifying the insured's annual earnings at the time of death (if the benefits are based on salary)	Ц	and/or toxicology report	
	If any portion of coverage is paid for by the insured, proof of payroll deduction.			

Return completed form to:

Blue Cross and Blue Shield of Texas (BCBSTX)
Attn: Life Claims Department • P.O. Box 7070 • Downers Grove, IL 60515

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Texas is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Page 1 of 4 z6294_BCBSTX



Life Insurance Claim Form

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Part 1: To be completed by Employer/Administrator

Employer/Group	o Informati	on						
Group Name:				Group Number:				
Subsidiary Name:				Account Number/Division:				
Group Address:	oup Address: Street:							
	City:			State:			Zip:	
Name and Title o	of Authorize	ed Representative:						
Phone:				Email:				
Preferred Comm	unication:	☐ Email ☐ Phone						
Employee Inform	mation							
Last Name:				First:			Middle:	
Street:							Birth Date:	
City:			State:		Zip:		Date of Dea	th:
Phone:				Email:				
Employee SSN / I	Employee SSN / ID:			Status:	□ Active	☐ Retired	□ Disabled	☐ Terminated
Date of Hire:	ate of Hire: Insurance Effective Date:			Last Day Worked: Date Terminated:			nated:	
Annual Salary:		Class:		Salary Effective Date:				
Employee's Date of Last Premium Contribution:				Hours Worked per Week:				
Deceased Inform	nation (lf o	ther than employee)						
□ Spouse □	⊐ Depende	nt Child						
Last Name:	ast Name:			First: Middle:				
Birth date:	irth date: Date of Death:			SSN:				
Full-Time Studen	Full-Time Student: ☐ Yes ☐ No			School:				
Was He/She Incapacitated and Reliant on the Employee for Financial Support: ☐ Yes ☐ No								
D.	o suro to i	include the Benefic	ciary Docig	nation w	han cub	mitting th	o Claim For	m
De	sure to	include the Benefic	lary Design	ilation w	ileli suc	initung tin	e Clailli Foi	····
Insurance Inform	mation							
Basic Life: \$			AD&D: \$					
Supplemental/Voluntary Life: \$			Supplemental/Voluntary AD&D: \$					
Additional Benefits: ☐ Seat Belt ☐ Airbag ☐ Education				□ Other:				
I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.								
Signature of Auth	norized Em	ployer/Plan Represen	tative				Date	

Return completed form to:

Blue Cross and Blue Shield of Texas
Attn: Life Claims Department • P.O. Box 7070 • Downers Grove, IL 60515



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Part 2: To be completed by Beneficiary

If there is more than one beneficiary, each must complete a separate form. See Important Information below if beneficiary is a minor.

· ·				· ·	
Beneficiary Information					
Last Name:	First:		Middle:		
Maiden Name:	Birth Date:	SSN / ID:			
Street:					
City:	State:	Zip:	Phone Number	per:	
Email:	Relationship to	Deceased:			
Deceased Information					
Last Name:	First:		Middle:		
SSN / ID:	Group Number/Name:				
IRS Certification					
	S Form W-8 is requ	uired. Provide oth	ner work ID if available.		
Under penalty of perjury, I certify that: 1. The number shown on this form is my 2. I am not subject to backup withholding by the Internal Revenue Service (IRS) the dividends, or (c) the IRS notified me th 3. I am a U.S. citizen or other U.S. person	g because: (a) I am nat I am subject to at I am no longer s	exempt from babackup withhole	ckup withholding, or (b) ding as a result of a failt	I have not been notified	
Certification Instructions You must cross out item 2 above if you h because of under reporting interest or d			ou are currently subject	to backup withholding	
The IRS does not require your consent to up withholding. If you fail to certify, we m				ons required to avoid back-	
Be sure to include a cer	tified copy of th	ne Death Certi	ficate for claims ove	er \$100,000.	
certify that I have read this document and files a statement of claim containing any fal					
Signature of Beneficiary			Dat	re	

IMPORTANT INFORMATION

If the Beneficiary is:

- a. A minor, an estate or incompetent to handle financial matters: provide an original court order appointing a legal representative or guardian to handle the financial affairs of the minor, the estate, or the incompetent.
- b. Deceased: provide proof of death, a copy of the final certified death certificate, and documentation of the secondary beneficiary.
- c. A trust: provide documentation verifying existence of the trust, documentation that the trust has been named the beneficiary, and the tax identification number of the trust.

Each beneficiary must complete and sign the Beneficiary/Claimant Statement



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Part 3: Authorization for Release of Information

(We will re	anire a	senarate	authorization ¹	for release	of no	vchotherany	(notes)
١	AAC AAIII I C	quii e a	3charate	authonization	101 1616936	OI DS	ychotherapy	/ 110163.)

I (the undersigned) authorize	of labor; law er	edically related facility; corone				
Deceased Last Name:		First:	Middle:			
SSN / ID:		Group Number/Name:				
I certify that I have read this document and the infor files a statement of claim containing any false or mis						
Signature of Beneficiary			Date			
 Claimant/Insured Information to be released: Data or records regarding medical history, treatmer prescriptions, consultations, autopsy (including mereports, records, charts, notes (excluding psychoth notes), x-rays, films or correspondence, and any mecondition(s)); Any information regarding insurance coverage; and Accident report or any official investigative reports police, fire, FAA, OSHA, or toxicology report). Information to be released to: Blue Cross and Blue Shield of Texas P.O. Box 7070 Downers Grove, IL 60515 I understand that refusal to sign this Authorization result in the denial of benefits. I understand the information used or disclosed mesubject to re-disclosure by the recipient and may allonger be protected by federal law. 	edical herapy nedical id s (such as	 I understand the information obtained by use of this Authorization will be used by BCBSTX (the Company) to evaluate my claim for death benefits. The Company will only release such information: To its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or As may be required by law; or As I further authorize. I understand that I may revoke this Authorization in writing at any time, except to the extent the Company has taken action in reliance on this Authorization. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signature below. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address. A photocopy of this Authorization is to be considered as valid as the original. I understand I am entitled to receive a copy of this signed Authorization. 				
Signature (Claimant or Legal Representative)	Print Name		Date			
If you are the legal representative of the Claimant, we ma	y ask for addition	onal documentation.				

Fraud Notice: The laws of some states require us to furnish you with the following notice for claims only:

Texas: 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.

State:

Phone Number:

Zip:

Street:

City: