wellabe®

Great Western
Insurance Company
A Wellabe Company

Death Claim Form

Submitted to Wellabe, Inc. (the "Company")*

The furnishing of this form and investigation of the claim is not to be construed as an admission of the validity of any claim or as a waiver of any condition of the policy by the Company.

Instructions for Filing a Claim

To avoid unnecessary processing delays, make sure you have:

- ❒ A completed and signed claim form
- ❒ A copy of the completed death certificate (need not be certified). Send within 30 days.
- ❒ Claims on First-Day coverage policies, within the two-year contestable period, need to have a completed death certificate indicating the cause of death attached to this claim form and the Medical Information Authorization, completed before payment will be made. Refund of premiums paid will be made immediately upon receipt of this form; all other amounts will be paid after the medical information and death certificate are received and reviewed.
- ❒ Claims on policies where the funeral home is not an assignee or beneficiary must be accompanied by a valid assignment with family signature and a filed death certificate.
- ❒ An itemized statement of all itemized bills for medical, hospital, or burial expenses actually incurred.

We suggest you keep a copy of all the information you send for your records.

Fax or email the completed claim form and all other necessary documents to:

Fax: 801-675-4685
Email: pnclaims@wellabe.com

We're here for you:

If you have any questions, please call us at 800-995-9010, Monday through Friday, 7:30 a.m. to 5 p.m. Central time.

* Great Western Insurance Company is a Wellabe company.

Death Claim Form

Claimant's (Family Representative) and Mortuary's Statement and Authorization of Payment

(Please print all information.)

We the undersigned hereby submit proof of death of _____

and state that the Insured was born on _____ and died on _____ and at the time of death was insured under policy number(s) _____.

1. What relation is claimant to deceased? _____
2. Is the claimant the beneficiary? ❒ Yes ❒ No If "No," the beneficiary is _____
3. What is the (non-funeral home) beneficiary's Social Security number? _____
4. Is this claim associate with a pre-need Funeral Services Agreement? ❒ Yes ❒ No If "Yes," list the funeral services and merchandise amount itemized in the agreement, $_____ and the cash advance amount, $_____.
5. Name and address of mortuary providing service: _____

   _____
6. The policy(ies) ❒ is lost ❒ was received and destroyed by the mortuary ❒ was returned with this claim
7. GREAT WESTERN INSURANCE COMPANY IS HEREBY AUTHORIZED TO PAY THE ABOVE NAMED MORTUARY (Check one) ❒ THE FULL DEATH BENEFIT, *OR* ❒ THE SUM OF $ _____ subject to the provisions of the above listed policy(ies) and the balance to _____ as payment on a funeral for the Insured.

We hereby agree that the designated mortuary has performed the services requested for the funeral of the Insured and my receive and receipt the above designated amount due and payable under the aforementioned policy(ies), which receipt shall be conclusive acknowledgment that we have received from the Company the sum specified in settlement of the policy(ies) listed above.

If the claimant is not the listed beneficiary on the policy, the claimant hereby acknowledges that he/she has authority to complete this authorization.

Signature of mortuary representative	*Signature of next of kin/family representative*
Mortuary providing services	Address
Date	City, State, ZIP code

For your protection, state law requires the following warning to appear on this form.

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

The furnishing of forms does not constitute an admission of liability on the part of the Company.

Medical Information Authorization

Please PRINT and complete if the policy is a non-guaranteed issue and has been in force for less than two policy years.

I hereby request and authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., Consumer Reporting Agency, or employer having information with respect to any illness or injury, medical history, consultations, prescriptions, or treatments, including x-ray plates and copies of all hospital or medical records pertaining to _____ to release and provide any and all such information to Great Western Insurance Company or its legal representative.

The information requested and authorized is to be used in establishing the extent of Great Western's liability in a claim which has been filed for the above person. This authorization may be revoked by written notice to the Company at its Executive Offices in Iowa at any time after this authorization has been signed. Any information obtained will not be released by Great Western Insurance Company to any persons or organizations except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with said claim, or as may be otherwise lawfully required or as I may further authorize.

I agree that, unless specifically revoked by written notice to the Company, this authorization will be valid for 120 days after it has been signed.

I know that I may request a copy of this Authorization. I agree that a photostatic copy of this Authorization shall be considered as effective and valid as the original.

Signature of next of kin, family representative, or legal representative	Date	Telephone number

Address	City	State	ZIP code

Physician's Information

Please list the physician(s) who treated the deceased during the two years prior to issuance of the policy.

Physician/Facility name	Telephone number

Address	City	State	ZIP code

Physician/Facility name	Telephone number

Address	City	State	ZIP code