PACIFIC LIFE

Group Critical Illness

Claim Statement Package

This package is to be used to file a claim under a Group Critical Illness policy. Failure to complete this form and all parts may result in delay of processing the claim. The following forms are included:

- Group Critical Illness - Insured/Patient Claim Statement
- Authorization for the Use and/or Disclosure of Information (Recommended)
- Authorization for Release of Claim Information (Recommended)
- Claim Fraud Statements
- Group Critical Illness - Attending Physician Statement

At Pacific Life, we are here to support you during the claims process. If you have any questions about this form or the required documentation, please reach out to us at (855) 810-3301 between 5 am and 5 pm, PT.

Additionally, you can consult your Certificate of Insurance and Schedule of Benefits for detailed information about your coverage. Keep in mind that there are specific rules — referred to as Limitations and Exclusions — that may apply during the claim evaluation. The information you provide in this claim package will be carefully reviewed to determine your eligibility for benefits.

Claim Submission Instructions:

1. Complete the **Group Critical Illness - Insured/Patient Statement**.
2. Review the fraud notices and sign the completed form where indicated.
3. Important additional documentation to submit with this form:
   - **Group Critical Illness - Attending Physician Statement**. Your physician will need to complete and sign.
   - Medical records that support diagnosis of the covered condition.
   - **Authorization for the Use and/or Disclosure of Information**. (Recommended)
4. Return documents to us at:
   - Email: claims.workforcebenefits@pacificlife.com
   - Mail to: Pacific Life Workforce Benefits - Claims, PO Box 2387, Omaha, NE 68103-2387
   - Fax: (949) 219-8872

Pacific Life & Annuity Company
Attn: Workforce Benefits – Claims
PO Box 2387 | Omaha NE 68103-2387
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Group Critical Illness – Insured/Patient Statement

Section 1: About the Primary Insured

First Name:	Middle Initial:	Last Name:	Suffix:
Address:		City:	State: / Zip Code:
Date of Birth (mm/dd/yyyy):	Social Security Number:	Policy Number:	Preferred Phone Number:
Email Address:		When was your last day actively at work? (mm/dd/yyyy):	

Section 2: About the Patient *(If applying for self, you do not need to complete Section 2.)*

First Name:	Middle Initial:	Last Name:	Suffix:
Date of Birth (mm/dd/yyyy):	Social Security Number:	Relationship to you? (check one) ☐ Spouse ☐ Child ☐ Domestic Partner	

Section 3: About the Critical Illness

Please select the condition for which you are applying. Please note not all conditions are covered under each policy. Refer to your certificate to confirm covered conditions.

Aneurysm
- ☐ Abdominal aortic
- ☐ Thoracic aortic
- ☐ Brain

Cancer
- ☐ Invasive
- ☐ Non-Invasive
- ☐ Skin Cancer

Coronary Artery Disease
- ☐ Bypass surgery
- ☐ Stent implantation
- ☐ Angioplasty or atherectomy

Hospitalization due to
- ☐ Infectious Disease
- ☐ Complications of Pregnancy

- ☐ Addison's Disease
- ☐ Advanced Alzheimer's or Dementia
- ☐ Advanced Parkinson's
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Benign Brain Tumor
- ☐ Bone Marrow Transplant
- ☐ Coma
- ☐ Covid 19
- ☐ End Stage Renal (Kidney) Failure
- ☐ Heart Attack
- ☐ Heart Catheterization
- ☐ Huntington's Disease
- ☐ Loss of Sight
- ☐ Loss of Speech
- ☐ Loss of Hearing
- ☐ Major Organ Failure without Kidney

- ☐ Multiple Sclerosis (MS)
- ☐ Occupational HIV
- ☐ Occupational Hepatitis
- ☐ Paralysis
- ☐ Severe Burns
- ☐ Stroke
- ☐ Sudden Cardiac Arrest

Childhood Conditions
- ☐ Autism Spectrum Disorder
- ☐ Cerebral Palsy
- ☐ Cleft Lip and/or Cleft Palate
- ☐ Cystic Fibrosis
- ☐ Down Syndrome
- ☐ Muscular Dystrophy
- ☐ Spina Bifida
- ☐ Type I Diabetes

Briefly describe the condition:

When were you diagnosed with this condition? (mm/dd/yyyy)	Were you previously diagnosed with this same condition? ☐ Yes ☐ No
When was your last day at work? (mm/dd/yyyy)	If Yes, Date of Diagnosis (mm/dd/yyyy):

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Group Critical Illness – Insured/Patient Statement

Section 4: Information About the Treatment
Complete this section to provide details related to the treatment received.
Attach a blank sheet with any additional provider details.

Physician Name:		Specialty:	
Address:		City:	State: Zip Code:
Phone Number:	Fax Number:	Date of First Visit (mm/dd/yyyy):	Date of Last Visit (mm/dd/yyyy):

Type of Visit (select only one)
☐ Chiropractor ☐ Emergency Room ☐ Primary Care Physician ☐ Specialist Physician ☐ Telemedicine ☐ Urgent Care ☐ Other:

Type of Care Received (select all that apply)
☐ Bloodwork ☐ CT scan ☐ MRI ☐ PET Scan ☐ Surgery ☐ X-Rays ☐ Other:

Physician Name:		Specialty:	
Address:		City:	State: Zip Code:
Phone Number:	Fax Number:	Date of First Visit (mm/dd/yyyy):	Date of Last Visit (mm/dd/yyyy):

Type of visit (Select only one)
☐ Chiropractor ☐ Emergency Room ☐ Primary Care Physician ☐ Specialist Physician ☐ Telemedicine ☐ Urgent Care ☐ Other:

Type of care received (Select all that apply)
☐ Bloodwork ☐ CT scan ☐ MRI ☐ PET Scan ☐ Surgery ☐ X-Rays ☐ Other:

Section 5: Hospital/Facility Information

Hospital/Facility:		Treating Physician:	
Address:		City:	State: Zip Code:
Phone Number:	Fax Number:	Date Admitted (mm/dd/yyyy):	Date Discharged (mm/dd/yyyy):

- The answers provided in this statement are true and complete to the best of my knowledge.
- I have read and understand the information in the Claim Fraud Statements section.
- I understand that I may consult with an independent financial, tax, or legal advisor, as needed. Pacific Life & Annuity Company will not provide me with any financial, tax, or legal advice or recommendations.

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Claim Fraud Statements

Please read the warning for your state.

General Fraud Warning: Any person who knowingly presents a false statement in a claim for insurance may be guilty of a criminal offense and subject to penalties under state law. (Not applicable in Virginia)

The laws of each state listed below require us to furnish you with the notice indicated below.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following disclosure: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly, and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit **or** who knowingly **or** willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: 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 CIVIL FINES AND CRIMINAL PENALTIES.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

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Group Critical Illness – Attending Physician Statement

Section 1: About the Primary Insured/Patient - Check Relationship: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child		
Primary Insured First Name:	Primary Insured Last Name:	Date of Birth (mm/dd/yyyy):
Patient Insured First Name:	Patient Insured Last Name:	Date of Birth (mm/dd/yyyy):

Section 2: Patient's Medical Condition *(To be completed by the Attending Physician)*
Please complete all applicable questions and provide copies of supporting medical information based on the condition.
Please sign and date the end of the form.

Diagnosis:	ICD Code:	Date of Diagnosis (mm/dd/yyyy):
Date you were first consulted for this condition (mm/dd/yyyy):	Last Office Visit (mm/dd/yyyy):	Next Office Visit (mm/dd/yyyy):

Aneurysm – Include a copy of medical records, including imaging used to diagnose.

Was your patient diagnosed with a bulge in an abdominal aortic, thoracic aortic, or brain vessel caused by a weakness in the blood vessel wall? Yes No	Was the diagnosis supported by radiographically specific studies? Yes No
Was surgery recommended for any of the following aneurysms? Abdominal Thoracic Brain	Date surgery was recommended (mm/dd/yyyy):

Cancer – Include a copy of the pathology report or clinical assessment with submission.

Select Cancer Type Invasive Non-Invasive Skin Cancer	Stage Details:	Was the cancer diagnosed: Pathologically Clinically	Date of biopsy or clinical diagnosis made (mm/dd/yyyy):

Coronary Artery Disease – Include a copy of assessment for surgery recommendation.

Was your patient diagnosed with a narrowing or blockage of one or more coronary arteries resulting from plaque buildup? Yes No	Was your patient recommended to undergo surgery? Check all that apply. Angioplasty Atherectomy Bypass surgery Stent implantation Other:	Date surgery was recommended (mm/dd/yyyy):

End Stage Renal (Kidney) Failure – Include copy of medical records confirming condition and recommended treatment.

Does the patient have irreversible failure of both kidneys? Yes No	Have you recommended regular hemodialysis or peritoneal dialysis at least weekly? Yes No	Date dialysis or transplant was recommended (mm/dd/yyyy):
Have you recommended the patient for a kidney transplant? Yes No	If no, provide details:	

Heart Attack – Include a copy of EKGs and lab results.

Were electrocardiographic (EKG) findings consistent with a myocardial infarction? Yes No	Did diagnostic studies confirm a myocardial infarction resulting from a blockage of one or more coronary arteries? Yes No	Were cardiac enzymes above standard laboratory levels of normal? Yes No	Level details: _____ _____ or _____ Troponin T Troponin L CPK-MB

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Major Organ Failure – Include a copy of surgical recommendation for transplant or UNOS placement.	
Was your patient diagnosed with failure or loss of one or more of the following organs? Liver Heart Lungs	Have you recommended the patient for an organ transplant? Yes No
If organ transplant not recommended, provide details:	

Stroke – Include a copy of medical imaging and assessments for neurological deficits.	
Did the patient have a stroke that resulted in permanent, neurological impairment and resulting in paralysis or other measurable objective neurological defect? (Stroke does not include transient ischemic attacks, brain injuries, ischemic disorders of the vestibular system, or vascular disease affecting the eye or optic nerve) Yes No	
Did a clinical diagnosis and neuroimaging study confirm this diagnosis? Yes No	Have neurological deficits been present for at least 30 days following the stroke? Yes No

Section 3: Treatment Details

Was the patient hospitalized? Hospital Location:

☐ Yes ☐ No

Was the hospitalization related to an ☐ infectious disease or ☐ complications of pregnancy? ☐ Yes ☐ No

ICU Admission Date (mm/dd/yyyy): ICU Discharge Date (mm/dd/yyyy): Admission Date (mm/dd/yyyy): Discharge Date (mm/dd/yyyy):

Did the patient have surgery? ☐ Inpatient ☐ Outpatient ☐ No	Surgery date (mm/dd/yyyy):	Surgery details:

Have you advised your patient to stop working? ☐ Yes ☐ No	Date advised to stop working (mm/dd/yyyy):	Date advised to return to work (mm/dd/yyyy):

What specific job duties is the patient unable to perform?

Restrictions and/or limitations:

Has the patient been treated by or referred to another physician for the same or similar condition? ☐ Yes ☐ No

Physician Name: Specialty:

Address: Phone Number: Fax Number:

Fraud Warning: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim.

Physician Name:	Specialty:		Physician Tax ID:
Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:		
Physician Signature:	Date Signed (mm/dd/yyyy):		