PACIFIC LIFE

Group Disability

Claim Statement Package

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

- Claim Fraud Statements
- Group Disability – Employee Claim Statement
- Authorization for the Use and/or Disclosure of Information
- Authorization for Release of Claim Information (Optional)
- Group Disability – Employer Statement
- Group Disability – 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 a.m. and 5 p.m., Pacific Time.

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. Review the **Claim Fraud Statements** form for the state in which you reside and the state in which your policy was issued.
2. Complete the **Group Disability – Employee Claim Statement** and the **Authorization for the Use and/or Disclosure of Information**. The **Authorization for Release of Claim Information** is an optional form should you wish to authorize an individual to have access to your claim information.
3. Have your employer complete the **Group Disability – Employer Statement**.
4. Have your treating physician complete the **Group Disability – Attending Physician Statement**. In addition, provide hospital discharge summaries and/or medical records which support your claim.
5. Return documents to us at:
   - Email: claims.workforcebenefits@pacificlife.com
   - Mail: Pacific Life & Annuity Company, Attn: Workforce Benefits - Claims, PO Box 2387, Omaha, NE 68103-2387
   - Fax: (949) 219-8872

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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 Disability - Employee Claim Statement

Section 1: Employee Information

First Name:	MI:	Last Name:	Suffix:

Date of Birth *(mm/dd/yyyy)*:	Social Security Number:	Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Widowed	State in which you work:

Address:	City:	State:	ZIP:

Preferred Phone Number:	Email Address:

Section 2: Employment Information

Employer Name: ☐ Self-employed

Employer Address:	City:	State:	ZIP:

Job Title:	Job Description:

Do you work for any other employer? ☐ Yes ☐ No If yes, please provide employer contact information:

Last Day Worked *(mm/dd/yyyy)*:	Number of hours worked on last day:	Return to Work Date *(mm/dd/yyyy)*: ☐ Expected ☐ Actual ☐ Unknown

Section 3: Event Information - Pregnancy/Injury/Sickness *(Check the appropriate box and complete the applicable section.)*

Diagnosed Condition(s):

First Treatment Date *(mm/dd/yyyy)*:	Last Office Visit *(mm/dd/yyyy)*:	Next Office Visit *(mm/dd/yyyy)*:

☐ Pregnancy

Expected Delivery Date *(mm/dd/yyyy)*:	Actual Delivery Date *(mm/dd/yyyy)*:	Delivery Type: ☐ Vaginal ☐ C-Section	Were there complications? ☐ Yes ☐ No

Were there any complications which prevented you from being able to work prior to delivery? ☐ Yes ☐ No
If yes, please provide a detailed explanation: *(Note: Reaching 36 weeks gestation, on its own, does not establish disability under the policy.)*

☐ Injury

Date of Injury *(mm/dd/yyyy)*:	Time of Injury *(estimate if unknown)*: ☐ a.m. ☐ p.m.	How did the injury occur? *(select one)* ☐ Motor Vehicle Accident ☐ Fall ☐ Lifting/Pushing/Pulling ☐ Other

Briefly describe what happened. *(Please attach a copy of the accident report or police report if applicable.)*

Is this considered the result of a work-related injury? ☐ Yes ☐ No Has a Workers' Compensation claim been filed? ☐ N/A ☐ Yes ☐ No
If a Workers' Compensation claim has been filed, please provide carrier, contact, and claim information:

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Group Disability - Employee Claim Statement *(continued)*

First Name:	MI:	Last Name:	Suffix:

Section 3: Event Information - Pregnancy/Injury/Sickness *(continued)*

☐ Sickness

Were you previously diagnosed with, or treated for, the same or similar condition(s)? ☐ Yes ☐ No
If yes, please provide condition(s) and diagnosis date(s) *(mm/dd/yyyy)*:

Facility/Hospitalization Information *(check all that apply)*:

☐ Urgent Care ☐ Emergency Room ☐ Surgical Center ☐ ICU ☐ Hospital (☐ Inpatient / ☐ Outpatient)

Facility/Hospital Name:

_____

Address: _____ City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

If confined to a facility/hospital, provide the dates of confinement:

Admit *(mm/dd/yyyy)* _____ Discharge *(mm/dd/yyyy)* _____ ☐ Duration Includes confinement in an ICU

Surgery/Procedure Date *(mm/dd/yyyy)*: ☐ N/A	Surgery/Procedure(s) Performed:

Please provide your treating provider's information: *(If multiple treating providers, please provide this information separately.)*

Treating Provider Name:

_____

Address: _____ City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

Section 5: Tax Information

Approved benefits may be taxable. Would you like Federal and/or State taxes withheld from eligible benefits?

Federal Income Tax Withholding: ☐ Yes ☐ No Amount: $_____ OR _____% *(per check)*

State Income Tax Withholding: ☐ Yes ☐ No Amount: $_____ OR _____% *(per check)*

Please Note: Taxes will not be withheld if benefits are not taxable. If your employer informs us benefits are taxable, we will withhold the minimum amount required.

Section 6: Attestation and Signature

- 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 will not provide me with any financial, tax, or legal advice or recommendations.

Signature:	Date Signed:

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Authorization for the Use and/or Disclosure of Information

Claimant/Employee/Retiree Name: ……………………………………………………………………… DOB: ……………………………

I authorize the use and disclosure of the following information so that Pacific Life & Annuity Company can evaluate the insurance claim on the above-named individual.

1. This authorization applies to the following information (whether from before, during or after the date of this authorization):

Any and all medical records: this includes, to the extent that the medical records include such information, information about HIV status, AIDS, other communicable or sexually transmitted diseases, mental health (other than "psychotherapy notes" that are kept separate from the medical record), any substance use disorder, and/or genetic information. Additionally, workers compensation information; postmortem examination, autopsy, toxicology records and reports; investigative reports; accident reports by law enforcement; paramedics records; employment incident reports; incident reports of any kind; photographs; insurance information; insurance claims records; financial and employment related information; and information regarding social security or other government benefits including benefit amounts and entitlement dates.

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of this information:

Health care professionals, hospitals, clinics, laboratories, pharmacies, emergency medical service agencies and all other medically related providers; medical examiner's offices, coroner's offices, health plans, insurance companies, third party administrators, law enforcement agencies, public safety departments, government agencies and entities (including to but not limited to federal, state, local and Social Security Administration), insurance producers, insurance service providers, credit bureaus, professional licensing bodies, consumer reporting agencies, reinsurers, employers, attorneys, financial institutions and/or banks.

3. I authorize the following persons (or class of persons) to receive this information:

Pacific Life & Annuity Company and its parent company.

4. Purpose of proposed use or disclosure:

For purposes of Pacific Life & Annuity Company evaluating and administering insurance claims.

5. I authorize Pacific Life & Annuity Company to share this information with:

The Group Insurance Plan as needed to perform its responsibilities under any benefit plan for the purpose of reporting claim status or experience, or so that the recipient may carry out health care operations, claims payment, administrative, or audit functions related to any benefit, plan or claim.

6. This authorization expires:

One year after the date of signature.

REFUSAL TO SIGN:

***You may refuse to sign this authorization**. A health care provider or health plan may not condition treatment, payment, enrollment, or eligibility for health plan benefits on your providing or refusing to provide this authorization. Your failure to sign this authorization, however, may result in Pacific Life & Annuity Company being unable to approve and pay this insurance claim.*

REDISCLOSURE:

Once your information is disclosed pursuant to this authorization, it may no longer be subject to federal and state law and may be subject to redisclosure. Pacific Life & Annuity Company will protect the privacy of this information in accordance with its privacy policy and other applicable law. For more information, you may visit https://www.pacificlife.com/home/privacy-and-other-policies/our-privacy-promise.html

REVOCATION:

You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to Pacific Life & Annuity Company at: PO Box 2387, Omaha, NE 68103-2387. Your revocation will not be effective to the extent that health care providers or health plans have already acted in reliance upon this authorization.

COPY OF AUTHORIZATION

You may request a copy of this authorization.

AUTHORIZATION

I understand and agree to the foregoing:

Signature ……………………………………… Date ……………………………

Print Name ……………………………………………………………………………

If signing as legal representative, describe your authority:

……………………………………………………………………………………………

Supporting Documentation must be attached.

…………………………………………………………………… ……………………………
Signature of Individual or Personal Representative   Date

Printed name of Personal Representative …………………………………………………

Relationship to Insured/Member ………………………………………………………………

(e.g. LEGAL GUARDIAN, EXECUTOR, ADMINISTRATOR, OR NEXT-OF-KIN)

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Authorization for Release of Claim Information

I authorize Pacific Life & Annuity Company to release information regarding the following individual:

Claimant/Employee Name _____
(First) *(MI)* *(Last)* *(Suffix)*

Date of Birth *(mm/dd/yyyy)* _____ Social Security Number _____

I authorize release of medical, claim, benefit, and financial information relating to insurance benefits for the above identified individual, unless otherwise specified:

_____

_____

Information is to be released to the following named party for the purpose of assisting with the insurance claim of the above identified individual:

Name of Company or Individual: _____

Address: _____ City: _____ St: _____ ZIP: _____

Telephone: _____ Email: _____

This authorization will remain valid during the claim(s) duration, but not for more than one year from the date signed.

I can revoke this authorization at any time by providing written notice for Pacific Life & Annuity Company by email, mail, or fax.

I understand that to the extent that information has been previously released, such revocation may not be effective.

Email: claims.workforcebenefits@pacificlife.com
Mail: Pacific Life & Annuity Company
Attn: Workforce Benefits - Claims
PO Box 2387
Omaha, NE 68103-2387
Fax: (949) 219-8872

Signature _____ Date _____

Print Name _____
First, MI, Last, Suffix (Include Title/Capacity and documentation, if applicable)

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Group Disability - Employer Statement

Section 1: Employer Information

Employer Name:		Employer Telephone Number:	
Employer Address:	City:	State:	ZIP:

Section 2: Employee Information

First Name:	MI:	Last Name:	Suffix:
Employee Address:	City:	State:	ZIP:
Social Security Number:	Employee Phone Number:	Employee Email Address:	
Date of Hire *(mm/dd/yyyy)*:	Job Title:		

Job Description and Physical Requirements: *(Attach written description if available.)*

	N/A	Occasionally	Frequently	Continuously
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Lift/Carry				
0-10 lbs	☐	☐	☐	☐
10-20 lbs	☐	☐	☐	☐
20-50 lbs	☐	☐	☐	☐
50-100 lbs	☐	☐	☐	☐
> 100 lbs	☐	☐	☐	☐

	N/A	Occasionally	Frequently	Continuously
Walk	☐	☐	☐	☐
Drive	☐	☐	☐	☐
Reach Above	☐	☐	☐	☐
Bend/Stoop	☐	☐	☐	☐
Twist	☐	☐	☐	☐
Push/Pull	☐	☐	☐	☐
Fine Manipulation	☐	☐	☐	☐

Stress Level ☐ Low ☐ Moderate ☐ High ☐ Very High

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Terminated - as of *(mm/dd/yyyy)*: _____

Work Schedule: ☐ Full Time ☐ Part Time Average hrs/wk: _____

Scheduled Days: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Section 3: Absence Information

Last Day Worked *(mm/dd/yyyy)*:	Hours Worked on Last Day:	Return to Work Date *(mm/dd/yyyy)*:	☐ Expected ☐ Actual ☐ Unknown ☐ Full Time ☐ Part Time - hrs/wk: _____

Is the condition considered work-related? ☐ Yes ☐ No

Has a workers' compensation claim been filed? ☐ Yes ☐ No ☐ Expected

If a workers' compensation claim has been filed, please provide carrier, contact, and claim information:

Sick Leave Exhausted on *(mm/dd/yyyy)*:	Can the employee's job be modified/accommodated if released with restrictions? ☐ Yes ☐ No If yes, Contact Name: Contact Phone:

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Group Disability - Employer Statement *(continued)*

First Name:	MI:	Last Name:	Suffix:

Section 4: Financial Information

a) Premiums and Deductions

What percentage of disability premiums are paid by the employee? ☐ N/A *(All disability premiums are paid by the employer.)*

Short Term Disability: _____% ☐ Pre-tax ☐ Post-tax Last Day Premiums Deducted *(mm/dd/yyyy)*: _____

Long Term Disability: _____% ☐ Pre-tax ☐ Post-tax

Pre-tax Withholdings:

Retirement Savings Plan _____% Pre-tax Medical and Other Insurance $_____ per _____

Is the employee subject to: Social Security Taxes ☐ Yes ☐ No Medicare Taxes ☐ Yes ☐ No

b) Salary

Payment Frequency: ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Yearly

Base Salary (excluding bonus, overtime, or commissions): $ _____

Total Bonus and Commissions over the last 24 months: $ _____

Effective Date of Last Salary Change *(mm/dd/yyyy)*: _____

If the earnings definition is based on prior year W-2, please include a copy of the W-2 OR provide year to date earnings and time period:

$ _____ From *(mm/dd/yyyy)*: _____ Through *(mm/dd/yyyy)*: _____

c) Other Income

Please indicate if the employee is receiving or eligible to receive any of the following:

		Amount	Frequency	Begin Date *(mm/dd/yyyy)*	End Date *(mm/dd/yyyy)*
Sick Leave	☐ Yes ☐ No	$			
Workers' Compensation	☐ Yes ☐ No	$			
Salary Continuance	☐ Yes ☐ No	$			
State Disability	☐ Yes ☐ No	$			
Paid Family Medical Leave	☐ Yes ☐ No	$			
Other Group Disability	☐ Yes ☐ No	$			
Other	☐ Yes ☐ No	$			

Section 5: Authorized Employer Contact - Information and Signature

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 Employer Statement portions of the claim.

Employer Contact Name:	Job Title:

Contact Phone Number:	Contact Email Address:

Signature:	Date Signed:

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Group Disability - Attending Physician Statement

Section 1: Patient Information

First Name:	MI:	Last Name:	Suffix:	Date of Birth *(mm/dd/yyyy)*:

Section 2: Patient's Medical Condition and Event Information

Diagnosis(es):	ICD Code(s):

☐ Pregnancy

Expected Delivery Date *(mm/dd/yyyy)*:	Actual Delivery Date *(mm/dd/yyyy)*:	Delivery Type: ☐ Vaginal ☐ C-Section

Were there complications which prevented your patient from being able to work prior to delivery? ☐ Yes ☐ No
If yes, please provide a detailed explanation: *(Note: Reaching 36 weeks gestation, on its own, does not establish disability under the policy.)*

☐ Injury

Please indicate the type of accident: ☐ MVA ☐ Fall ☐ Lift/Push/Pull ☐ Other _____	Is the current condition the result of a work-related injury? ☐ Yes ☐ No

☐ Sickness

Has your patient has been treated for the same or similar condition(s) in the past? ☐ Yes ☐ No
If yes, please provide condition(s) and treatment dates *(mm/dd/yyyy)*:

First Treatment Date *(mm/dd/yyyy)*:	Did you advise your patient to stop working? ☐ Yes ☐ No If Yes, as of what date *(mm/dd/yyyy)*? _____

Last Office Visit *(mm/dd/yyyy)*:	Height/Weight/BP as of Last Office Visit: H: _____ft _____in W: _____lbs BP: _____/_____	Next Office Visit *(mm/dd/yyyy)*:

Facility/Hospitalization Information *(check all that apply)*:
☐ Urgent Care ☐ Emergency Room ☐ Surgical Center ☐ ICU ☐ Hospital (☐ Inpatient /☐ Outpatient)

Facility/Hospital Name:

_____

Address: City: State: ZIP:

_____ _____ _____ _____

Phone Number: Fax Number:

_____ _____

If confined to a facility/hospital, provide the dates of confinement:

Admit *(mm/dd/yyyy)* _____ Discharge *(mm/dd/yyyy)* _____

Procedure(s) Performed:	CPT Code(s):

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Group Disability - Attending Physician Statement *(continued)*

First Name:	MI:	Last Name:	Suffix:	Date of Birth *(mm/dd/yyyy)*:

Section 3: Treatment Plan

Provide your treatment plan including expected duration, frequency of visits, prescribed medication, etc.:

Released to Return to Work *(mm/dd/yyyy)*:

_____ ☐ Expected Release ☐ Actual Release ☐ Released with Restrictions ☐ Unknown

If your patient has ongoing restrictions and limitations preventing their return to work or has been released with restrictions, please provide specific restrictions and their duration:

Expected Duration of Restrictions: From *(mm/dd/yyyy)* _____ Through *(mm/dd/yyyy)* _____

If your patient was referred **to** you by another provider or referred **from** you to another provider, please include the provider's information:

☐ N/A
☐ TO you from:
☐ FROM you to:

Physician Name: _____ Specialty: _____

Address: _____ City: _____ State: _____ ZIP: _____

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:	
Address:	City:	State:	ZIP:
Phone Number:	Fax Number:	Physician Tax ID:	
Physician Signature:		Date Signed:	