PACIFIC LIFE

Group Hospital Indemnity

Claim Statement Package

This package is to be used by the primary insured to file a claim under a Group Hospital Indemnity 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 Hospital Indemnity – Insured/Patient Claim Statement
Authorization for the Use and/or Disclosure of Information (Recommended)
Authorization for Release of Claim Information (Optional)
Group Hospital Indemnity – 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, sign, and date the **Group Hospital Indemnity – Insured/Patient Statement**.
3. (Recommended) Complete, sign, and date the **Authorization for the Use and/or Disclosure of Information**. Note: This form should be signed by the patient if over the Age of Majority in their state of residence (i.e., self, spouse/partner, or adult child).
4. Have the **Group Hospital Indemnity – Attending Physician Statement** completed by the treating physician. 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 Hospital Indemnity – Insured/Patient Claim Statement

Section 1: About the Primary Insured

First Name:	Middle Initial:	Last Name:	Suffix:
Address:		City:	State: ZIP:
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 ☐ Domestic Partner ☐ Child	

Section 3: Illness Event Complete this section for an Illness related claim.

What type of condition are you filing for?	When were you diagnosed with this condition? (mm/dd/yyyy):	First treatment date (mm/dd/yyyy):	Last treatment date (mm/dd/yyyy):
Were you previously diagnosed with this same condition? ☐ Yes ☐ No		If Yes, Date of Diagnosis (mm/dd/yyyy):	

Section 4: Injury Event Complete this section for an Injury related claim.

Date and time of injury (mm/dd/yyyy): ☐ a.m. ☐ p.m.	How did the injury occur? (select one) ☐ Fall ☐ Motor Vehicle Accident ☐ Playing Organized Sports ☐ Other
Briefly describe what happened.	
Did this injury occur at work? ☐ Yes ☐ No	What type of injury was sustained? (select all that apply) ☐ Fractured bone ☐ Burn ☐ Concussion or Head Injury ☐ Dislocation ☐ Dismemberment ☐ Laceration ☐ Other:

Section 4: Pregnancy *(Refer to your Certificate for applicability of Child Birth coverage.)*

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 causing the patient to stop working prior to their expected delivery date? ☐ Yes ☐ No
If yes, please explain.

Were there any postpartum complications for mother or baby that required hospitalization? ☐ Yes ☐ No
If yes, please explain.

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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:
Phone Number:	Fax Number:	Date of First Visit (mm/dd/yyyy):	Date of Last Visit (mm/dd/yyyy):	

Type of visit (select 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:
Phone Number:	Fax Number:	Date of First Visit (mm/dd/yyyy):	Date of Last Visit (mm/dd/yyyy):	

Type of visit (select 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: Hospitalization details

Hospital Name:		Treating Physician:		
Address:		City:	State:	ZIP:
Phone Number:	Fax Number:	Date Admitted (mm/dd/yyyy):	Date Discharged (mm/dd/yyyy):	

Section 6: Signature

By signing in the Signature section, I attest that:

- 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 Claims 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.

Signature: _____ Date: _____

Print Name (include Title/Capacity, if applicable): _____

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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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Group Hospital Indemnity – 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 First Name:	Patient Last Name:	Date of Birth (mm/dd/yyyy):

Section 2: Patient's Medical Condition *(To be completed by the Attending Physician)*
Instructions: 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):
Is this condition related to an illness or injury? ☐ Illness ☐ Injury ☐ Unknown	Date of Injury/Accident (mm/dd/yyyy):	Was the patient treated in the Emergency Room? ☐ Yes ☐ No

Is the condition work related? ☐ Yes ☐ No	Accident Description:	Date of treatment (mm/dd/yyyy):

Was the patient hospitalized? ☐ Yes ☐ No

Hospital Name and Location: _____

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 performed: _____

Did the patient have a diagnostic exam performed? ☐ Yes ☐ No
Diagnostic exam date (mm/dd/yyyy): _____ Diagnostic exam performed: _____

Did you prescribe occupational therapy, physical therapy, rehabilitation therapy or speech therapy? ☐ Yes ☐ No
Frequency prescribed or date(s) of treatment: _____

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): _____

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:
Phone Number:	Fax Number:		
Physician Signature:		Date Signed (mm/dd/yyyy):	