PACIFIC LIFE

Group Life Insurance

Waiver of Premium While Totally Disabled

Claim Statement Package

This package is to be used by Employees who want to file a claim for the Group Life Insurance - Waiver of Premium Benefit While Totally Disabled. The following statements are included:

- Claim Fraud Statements
- Group Life Insurance – Waiver of Premium While Totally Disabled – Employee Statement Instructions
- Group Life Insurance – Waiver of Premium While Totally Disabled - Employee Statement
- Group Life Insurance – Waiver of Premium While Totally Disabled – Employer Statement Instructions
- Group Life Insurance – Waiver of Premium While Totally Disabled - Employer Statement
- Authorization for the Use and/or Disclosure of Information (Recommended)
- Authorization for Release of Claim Information (Optional)
- Attending Physician Statement for Waiver of Premium While Totally Disabled

Pacific Life & Annuity Company
Workforce Benefits
PO Box 2387
Omaha NE 68103-2387
PH (855) 810-3301 Fax (949) 219-8872
claims.workforcebenefits@pacificlife.com

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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Employee Instructions for Group Life Insurance - Waiver of Premium While Totally Disabled - Employee Statement

Pacific Life is here to help you in submitting claims as timely as possible. If you have any questions about this statement or the documentation required, please call us at (855) 810-3301 from 5 am through 5 pm, PT. We are here to support you through this process.

The **Group Life Insurance - Waiver of Premium Benefit While Totally Disabled Statements:** Are used when an employee has ceased active work due to total disability and seeks to have eligible insurance extended while premium payments are waived. The employee must meet policy requirements to qualify.

Please complete the following steps:

1. Your employer/group policyholder will need to complete and provide the **Group Life Insurance - Waiver of Premium While Totally Disabled - Employer Statement.**
2. You, as the Employee, will need to complete Section 1 of the **Group Life Insurance - Waiver of Premium While Totally Disabled - Employee Statement** providing your personal information.
3. Complete Section 2 adding information/dates about your disability and stopping work.
4. Complete Section 3 listing background information regarding your education and work experience, as well as current and past employment.
5. Complete Section 4 providing your primary care team contact information, any other physicians being seen, and any hospitalizations that have occurred.
6. Review the Claims Fraud Statement and complete Section 5 by signing the form.
7. Important additional documentation to submit with this statement:

   ☐ **Group Life Insurance – Waiver of Premium While Totally Disabled - Attending Physician Statement.** Your treating physician will need to complete the statement.

   ☐ **Authorization for the Use/or Disclosure of Information.** This statement will allow Pacific Life to request any additional needed medical or other supporting documentation.

   ☐ Any supporting medical records and/or hospital records, office notes, discharge summaries, lab results, etc. that provide documentation of your total disability.

8. Return documents by one of the following methods:

   ☐ Email: Claims.workforcebenefits@pacificlife.com

   ☐ Fax: (949) 219-8872

   ☐ Mail: Pacific Life & Annuity Company
   Attn: Workforce Benefits – Claims
   PO Box 2387
   Omaha, NE 68103-2387

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Group Life Insurance - Waiver of Premium While Totally Disabled – Employee Statement

Section 1: Information about yourself

Employee Name (First, MI, Last):	Date of Birth (mm/dd/yyyy):	Social Security Number:	
Address:	City:	State:	ZIP:
Telephone Number:	Email:	Married? ☐ Yes ☐ No	
Employer/Group Policyholder:			

Section 2: Information about your disability

Date last worked:	Date of disability:	Expected return to work date:

Is your disability due to ☐ Accident ☐ Illness

What medical condition is preventing you from working?

Are you able to engage in any gainful occupation? ☐ Yes ☐ No
If yes, please provide details:

Did disability result from employment? ☐ Yes ☐ No
If yes, please provide details:

Section 3: Information about your education and work experience

Are you currently working for another employer or self-employed? ☐ Yes ☐ No
If yes, occupation? Date of hire?

Were you in the military? ☐ Yes ☐ No
Branch:_____
Rank:_____
Specialty:_____

Did you graduate high school? ☐ Yes ☐ No
If not, highest grade?_____
Completed GED?_____

Did you attend college? ☐ Yes ☐ No
Did you graduate? ☐ Yes ☐ No
Degree(s) Earned: _____
_____

Did you have any formal or vocational training?
☐ Yes ☐ No
Please list: _____
_____

Employer Name:	Dates of Employment: (mm/dd/yyyy) _____ to _____	Base Salary/hourly wage: $_____ ☐ hour ☐ year	Occupation/job title:
Employer City:	State:	Brief job description:	
Employer Name:	Dates of Employment: (mm/dd/yyyy) _____ to _____	Base Salary/hourly wage: $_____ ☐ hour ☐ year	Occupation/job title:
Employer City:	State:	Brief job description:	
Employer Name:	Dates of Employment: (mm/dd/yyyy) _____ to _____	Base Salary/hourly wage: $_____ ☐ hour ☐ year	Occupation/job title:
Employer City:	State:	Brief job description:	

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Section 4: Information about your Treatment Providers

Please provide information on your primary care team:

Physician Name:			Telephone Number:		Fax Number:
Office Address:	Suite:	City:	State:	ZIP:	Specialty:
First Office Visit:			Last Office Visit:		

Please provide any additional treating providers:

Physician Name:			Telephone Number:		Fax Number:
Office Address:	Suite:	City:	State:	ZIP:	Specialty:
First Office Visit:			Last Office Visit:		

Physician Name:			Telephone Number:		Fax Number:
Office Address:	Suite:	City:	State:	ZIP:	Specialty:
First Office Visit:			Last Office Visit:		

List any hospital confinement associated with your disability:

Hospital:		Telephone Number:		Fax Number:
Address:	City:	State:	ZIP:	Dates of Confinement (mm/dd/yyyy): _____ to _____
Hospital:		Telephone Number:		Fax Number:
Address:	City:	State:	ZIP:	Dates of Confinement (mm/dd/yyyy): _____ to _____

Section 5: 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.

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATIONS REQUIRED TO AVOID BACKUP WITHHOLDING.

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 material 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.

Signature: _____ Date: _____

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

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Employer Instructions for
Group Life Insurance - Waiver of Premium While Totally Disabled - Employer Statement

Pacific Life is here to assist you and your employees in submitting claims as timely as possible. If you have any questions regarding this statement or the documentation required, please reach out to us at (855) 810-3301 from 5 am through 5 pm, PT.

The **Group Life Insurance - Waiver of Premium Benefit While Totally Disabled Statements:** Are used when an employee has ceased active work due to total disability and seeks to have eligible insurance extended while premium payments are waived. The employee must meet policy requirements to qualify.

Please complete the following steps:

1. Complete Section 1 of the **Group Life Insurance - Waiver of Premium While Totally Disabled - Employer Statement** indicating group policyholder, policy, and employer contact information
2. Complete Section 2 of the Statement providing information on the Employee, Employee's hire dates, date employee was last physically completing the job, wage information, and coverage amount information.
    - Review the **Claim Fraud Statements,** then sign the document in Section 3.
    - We may request payroll documentation to calculate the benefit per the earnings definition as defined in the policy.
3. Provide the Employee with the following documents in this package:
    - **Group Life Insurance - Waiver of Premium While Totally Disabled - Employer Statement**
    - **Group Life Insurance – Waiver of Premium While Totally Disabled - Attending Physician Statement**
    - **Authorization for the Use and/or Disclosure of Information**
4. Please notify the employee that we will require:
    - Copy of medical records and hospital records that support the total disability.
5. Return documents by one of the following methods:
    - Email: Claims.workforcebenefits@pacificlife.com
    - Fax: (949) 219-8872
    - Mail: Pacific Life & Annuity Company

      Attn: Workforce Benefits – Claims

      PO Box 2387

      Omaha, NE 68103-2387

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Group Life Insurance - Waiver of Premium While Totally Disabled – Employer Statement

Section 1: Employer/Group Policyholder Information

Employer Name:	Policy Number:		
Address:	City:	State:	ZIP:
Name of Person Completing the Form:	Title of Person Completing the Form:		
Telephone Number:	Email Address:		

Section 2: Employee Information

Employee Name (First, MI, Last):		Social Security Number:	Date of Hire:	Effective Date of Employee Insurance:
Employee's Last Day Physically at Work:	Employee's Premium Paid through date:	Employee Terminated? ☐ Yes ☐ No If Yes, date:	Insurance Class:	Occupation:
Date of Last Pay Increase:	Employee pay was: Hourly-Per hour $_____ or Salary-Annual salary $_____		Check all that are included in pay: ☐ Commission ☐ Bonuses ☐ Overtime	
Average Hours worked per Week:	Reason employee stopped working: ☐ Illness/Injury ☐ FMLA ☐ Resigned/Dismissed ☐ Retiree ☐ Other (specify) _____			

Amount of Insurance claimed for Employee:

Basic Life $_____ Basic AD&D $_____ Voluntary Life $_____ Voluntary AD&D $_____

Dependent Spouse Coverage? ☐ Yes ☐ No Amount $_____ Dependent Child Coverage? ☐ Yes ☐ No Amount $_____

If Yes, please provide:

Spouse Name/Date of Birth: _____

Child(ren) Name(s)/Date(s) of Birth: _____

_____

Is claim being made for Worker's Compensation or similar benefits? ☐ Yes ☐ No

Was the insured employed with the group policyholder when the disability began? ☐ Yes ☐ No

Has the employee returned to work? ☐ Yes ☐ No If Yes, date:

Section 3: Signature

I hereby verify that the information provided on this claim form is accurate and complete in accordance with employer records. I am authorized to provide this information on behalf of the employer.

Signature: _____ Date: _____

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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 Life Insurance - Waiver of Premium While Totally Disabled Attending Physician Statement

Section 1: Information about Patient

Employee Name (First, MI, Last):	Date of Birth (mm/dd/yyyy):	Social Security Number (last 4 digits):

Telephone Number:	Address:	City:	State:	Zip:

Section 2: Information about the Medical Condition

Date of first office visit:	Most recent visit?	How often do you see this patient?

Symptoms resulted from?	When did symptoms first appear?	Is condition work related?	Did you advise the patient to cease work?
☐ Illness ☐ Accident		☐ Yes ☐ No	☐ Yes ☐ No If yes, date:

Height: Weight: Blood Pressure:

Primary Diagnosis include ICD or DSM code: _____ _____ Diagnosis: _____

Secondary Diagnosis include ICD or DSM code: _____ _____ Diagnosis: _____

Patient's Progress: ☐ Unchanged ☐ Retrogressed ☐ Improved ☐ Recovered

Subjective Symptoms:

Objective Findings: (include copies of any X-rays, lab tests, EKGs, MRIs, scans, and office notes)

Are there other conditions contributing? ☐ Yes ☐ No

If yes, please explain: _____

Current and Recommended Treatment Plans:

Has the patient had surgery? ☐ Yes ☐ No Please detail including procedure and date(s):

Is more surgery anticipated? ☐ Yes ☐ No Please detail including procedure and date(s):

Have you referred the patient to other specialists/physicians? ☐ Yes ☐ No Please indicate Name(s) and telephone number(s):

Has the patient been hospital confined? ☐ Yes ☐ No

If yes, please provide details: _____

_____

Dates of Confinement: From:_____ to:_____ From:_____ to:_____ From:_____ to:_____ From:_____ to:_____

Hospital: _____ Address: _____

Hospital: _____ Address: _____

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Patient Name:	Claim Number (if available):

Section 2: Information about the Medical Condition (continued)

Please provide medications and dosages prescribed:

_____ _____ _____

_____ _____ _____

Has maximum medical improvement been reached? ☐ Yes ☐ No

If no, what is expected timeframe for it to be reached? _____

Section 3: Information about Physical Capacities

Please detail any limitations and expected timeframe for limitation:

Please detail any restrictions and expected timeframe for restrictions:

Patient is able to do the following: (choose one)

Sit for: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 hours at a time

Stand for: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 hours at a time

Walk for: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 hours at a time

Comments

Bend ☐ Yes ☐ No _____

Squat ☐ Yes ☐ No _____

Crawl ☐ Yes ☐ No _____

Climb ☐ Yes ☐ No _____

Operate a motor vehicle ☐ Yes ☐ No _____

Reach above shoulder level ☐ Yes ☐ No _____

Use of hands in repetitive actions ☐ Yes ☐ No _____

Use of feet in repetitive actions ☐ Yes ☐ No _____

Dominant Hand ☐ Left ☐ Right

Patient is able to lift/carry	Never 0%	Occasionally 1-33%	Frequently 34-66%	Constantly 67-100%
Up to 10 lbs.				
11 to 20 lbs.				
21 to 50 lbs.				
51 to 100 lbs.				

Comments:

Would you recommend ☐ occupational, ☐ physical, or ☐ vocational rehabilitation for this patient?

☐ Yes ☐ No

Comments:

What is cardiac functional capacity (American Heart Association)? Mark only if applicable to condition.

☐ Class 1 No Limitation ☐ Class 2 Slight Limitation ☐ Class 3 Marked Limitation ☐ Class 4 Complete Limitation

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Patient Name:	Claim Number (if available):

Section 4: Work Capabilities

In your opinion, why is the patient unable to perform the job duties?

Is the patient capable of working within these limitations? ☐ Yes ☐ No

Patient can work _____ hours per day and _____days per week

If no, is the patient currently totally disabled from Own Occupation? ☐ Yes ☐ No

Patient can work _____ hours per day and _____days per week

Is the patient currently totally disabled from Any Occupation? ☐ Yes ☐ No

Patient can work _____ hours per day and _____days per week

If currently disabled, when do you think the patient can return to work?

Section 5: Signature of Attending Physician

The above statements are accurate and complete to the best of my knowledge and belief.

Physician Name:	Degree:	Specialty:	
Address:	City:	State:	Zip:
Telephone:	Fax:		
Signature of Attending Physician: X		Date:	

I have included the following:

☐ Office Notes ☐ MRIs ☐ Scans ☐ EKGs ☐ X-Rays ☐ Lab Results

Contact person if additional information is needed:

Name: