Health Net Life Insurance Company (Health Net)

Group Life Insurance Claim Form

Attn: Life Claims
PO Box 10427
Van Nuys, CA 91410-0427
1-800-635-5832

Claim for: ☐ Employee Life and AD&D
☐ Dependent Life
☐ Supplemental Life

Attach certified death certificate. Please see reverse for instructions.

Section A – Policyholder statement to be completed by employer

A1. Employee name: Last:	A2. First:	A3. MI:	A4. Employee SSN:	A5. Employee DOB: / /
A6. Insured name: Last:	A7. First:	A8. MI:	A9. Insured SSN:	A10. Insured DOB: / /

A11. Policyholder #:	A12. Policyholder name:	A13. Employee occupation/ Job title:	A14. Employee class (if applicable):
A15. Basic annual earnings:	A16. Reason for stopping work (if applicable): ☐ Resigned ☐ Illness ☐ Layoff ☐ Retired ☐ Leave ☐ Vacation ☐ Other _____		

A17. Employee date of hire: / /	A18. Effective date of coverage: / /	A19. Last date of full-time active work for employer: / /	A20. Date premiums are paid to: / /

A21. Cause of death (Attach additional sheet, if needed.):	A22. Date of death: / /	A23. Place of death:
A24. Did deceased have Accidental Death & Dismemberment coverage? ☐ Yes ☐ No	A25. Are accidental death benefits being claimed? ☐ Yes ☐ No (If "Yes," additional documentation necessary.)	

A26. Amount of insurance claimed:
$_____ Basic $_____ Supp $_____ AD&D $_____ Dep

Section B – Named beneficiary(ies) statement to be completed by employer

B1. Name of beneficiary:	B2. Age:	B3. SSN:	B4. Relationship to deceased:
B5. Beneficiary's mailing address:			
B6. Name of beneficiary:	B7. Age:	B8. SSN:	B9. Relationship to deceased:
B10. Beneficiary's mailing address:			

B11. Do you recommend payment of this claim? ☐ Yes ☐ No
Remarks: _____

Mail check to: ☐ Employer at address shown ☐ Beneficiary at address shown ☐ Other (Specify in cover letter.)

B12. Signature of employer representative: X	B13. Title of employer representative:	B14. Phone #:	B15. Date: / /

B16. Employer address: Street:	B17. City:	B18. State:	B19. ZIP:

Section C – Attending physician statement

If deceased was disabled more than 31 days prior to death, please have this statement completed by the physician who treated him or her during this disability.

C1. Full name of deceased:		C2. Date of death: / /	C3. Age:
C4. Place of death:	C5. Date of first visit: / /	C6. Date of last visit: / /	
C7. Immediate cause of death:		C8. Duration:	
C9. Contributory causes or complications:		C10. Duration:	

C11. Death resulted from:
☐ Natural causes ☐ Accident ☐ Suicide ☐ Homicide

C12. If due to accident, suicide or homicide, describe briefly:

_____

C13. Signature: I hereby certify that the above answers are true and complete to the best of my knowledge and belief.

X C14. Date: / /

C15. Address:	C16. City:	C17. State:	C18. ZIP:	C19. Phone #:

Section D – Instructions

1. The employer or a representative of the employer must complete the Policyholder Statement and Named Beneficiary(ies) Statement.
2. A completed W-9 Form, signed by the Beneficiary(ies) or Representative of a Beneficiary(ies), must be submitted with the Claim Form to Health Net.
3. If any of the beneficiaries named in the policy are deceased, a **certified** copy of the death certificate of such deceased beneficiary must accompany the Beneficiary/Claimant Statement.
4. If the policy is payable to the estate or to the executors or administrators of the Insured, a certificate of the appointment and estate identification number must be furnished.
5. If the policy is payable to a minor or a mentally incompetent person, a certificate of the guardian's appointment of the minor's or mentally incompetent person's estate is to be furnished.
6. If claiming accidental death benefits, provide a detailed accident report, police report, newspaper article, or any other pertinent information concerning the accident.
7. It is only necessary to complete the Attending Physician's Statement if the decedent was disabled more than 31 days prior to death. If applicable, the physician who treated the decedent during the disability should complete and sign this statement.

Note: The cost, if any, of completing and/or obtaining necessary claim papers is to be borne by the Beneficiary/Claimant.

Self-administered groups only

1. In addition to the above requirements, please submit the original enrollment card and all applicable change forms.
2. If the life benefit is based on salary, please submit payroll documents which verify the decedent's annual earnings at the time of death.

For residents of California

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may also be subject to fines and confinement in state prison.

A certified copy of the insured's death certificate must accompany this form.

Nondiscrimination Notice

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, gender affirming care, sexual orientation, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at: 800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

Health Net of California, Inc., Appeals & Grievances
PO Box 10348, Van Nuys, CA 91410-0348

Fax: 1-877-831-6019
Email: Member.Discrimination.Complaints@healthnet.com (Members)

If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or call 1-800-522-0088 (TTY: 711).

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية، أو اتصل على مركز الاتصال التجاري (TTY: 711) 1-800-522-0088

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք 1-800-522-0088 (TTY: 711).

Chinese
免費語言服務。您可使用口譯員。您可請人使用您的語言將文件內容唸給您聽，並請我們將有您語言版本的部分文件寄給您。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡，或致電 1-800-522-0088 (TTY: 711)。

Hindi
बिना लागत की भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आपको दस्तावेज पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपके आईडी कार्ड पर दिए गए सूचीबद्ध नंबर पर हमें कॉल करें, या 1-800-522-0088 (TTY: 711)।

Hmong
Kev Pab Txhais Lus Dawb. Koj xav tau neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv kom yog koj hom lus los tau. Xav tau kev pab, hu peb tau rau tus xov tooj ntawm koj daim npav los yog hu 1-800-522-0088 (TTY: 711).

Japanese
無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話いただくか、1-800-522-0088 、(TTY: 711)。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ ទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មនៃក្រុមហ៊ុន 1-800-522-0088 (TTY: 711).។

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 귀하가 구사하는 언어로 문서의 낭독 서비스를 받으실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 수록된 번호로 전화하시거나 1-800-522-0088 (TTY: 711).

Navajo
Saad Bee Áká E'eyeed T'áá Jíík'e. Ata' halne'ígíí hóló. T'áá hó hazaad k'ehjí naaltsoos hach'i' wóltah. Shíká a'doowoł nínízingo naaltsoos bee néího'dólzinígíí bikáa'gi béésh bee hane'í bikáá' áajį' hodíílnih éí doodaii' 1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند. برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید یا با مرکز تماس بازرگانی 1-800-522-0088 (TTY: 711).

Panjabi (Punjabi)
ਬਨਿਾਂ ਕਸਿੇ ਲਾਗਤ ਤੋ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ਿਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਚਿ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦੱਤਿ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਰਿਪਾ ਕਰਕੇ 1-800-522-0088 (TTY: 711).

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Кроме того, вы можете позвонить в 1-800-522-0088 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o comuníquese con el 1-800-522-0088 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card o tawagan ang 1-800-522-0088 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ โทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-800-522-0088 (TTY: 711)

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị hoặc gọi 1-800-522-0088 (TTY: 711).