Health Net®
LIFE INSURANCE COMPANY

Life Insurance Claim Form

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

Attn: Life Claims
PO Box 10427
Van Nuys, CA 91410-0427

1-800-635-5832

Attach certified death certificate. Please see reverse for instructions.

Part I. Policyholder statement to be completed by employer

Employee name: Last:	First:	MI:	Employee SSN:	Employee DOB: / /
Insured name: Last:	First:	MI:	Insured SSN:	Insured DOB: / /

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

Employee date of hire: / /	Effective date of coverage: / /	Last date of full-time active work for employer: / /	Date premiums are paid to (if contributory, date to which contribution has been paid): / /

Cause of death (Attach additional sheet, if needed.):	Date of death: / /	Place of death:

Did deceased have Accidental Death & Dismemberment coverage? ☐ Yes ☐ No	Are accidental death benefits being claimed? ☐ Yes ☐ No (If "Yes," attach news clipping or police report.)

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

Part II. Named beneficiary(ies) statement to be completed by employer

Name of beneficiary:	Age:	SSN:	Relationship to deceased:
Beneficiary's mailing address:			
Name of beneficiary:	Age:	SSN:	Relationship to deceased:
Beneficiary's mailing address:			

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)

Signature of employer representative: X	Title of employer representative:	Phone #:	Date: / /

Employer address: Street:	City:	State:	ZIP:

(continued)

Part III. Attending physician statement

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

Full name of deceased:		Date of death: / /	Age:
Place of death:	Date of first visit:	Date of last visit:	
Immediate cause of death:		Duration:	
Contributory causes or complications:		Duration:	

Death resulted from: ☐ Natural causes ☐ Accident ☐ Suicide ☐ Homicide If due to accident, suicide or homicide, describe briefly:	Decedent was totally disabled and unable to work: From: / / To: / /

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

X Date: / /

Address:	City:	State:	ZIP:	Phone #:

Part IV. Instructions

1. The employer or a representative of the employer must complete the Policyholder Statement and Named Beneficiary(ies) Statement.
2. 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.
3. 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.
4. 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.
5. If claiming accidental death benefits, provide a detailed accident report, police report, newspaper article, or any other pertinent information concerning the accident.
6. 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.