BANKERS LIFE AND CASUALTY COMPANY Life Claims Department - P.O. Box 1937 Carmel, Indiana 46082-1937 (800) 621-3714



INTRODUCING... the Bankers Benefit NOW Account®

At the Bankers insurance companies, we're dedicated to helping you make timely and sound decisions regarding your financial future. Depositing your insurance proceeds into a secure Bankers Benefit NOW Account allows you all the time you need to contemplate your next step in life. You may rest assured that your funds are available to you whenever you need them and earning interest until you decide how they fit into your overall financial plan.

You may be asking, "What is a Bankers Benefit NOW Account?"

The Bankers Benefit NOW Account is an interest-bearing draft account and is our primary method of paying insurance proceeds over \$5,000. By simply writing a draft, you have immediate access to your funds whenever you need them.

Benefit NOW may not be available in all states or with some products. If a Benefit NOW account cannot be established, a single check will be issued to you.

You have access to your funds whenever you need them.

By simply writing a draft, you have access to your funds whenever you need them. There are no penalties for withdrawing any or all of your funds at any time.

Earn interest on your balance as you review your financial options.

Your Bankers **Benefit** NOW **Account** will begin earning interest on the day it is established. Interest is compounded daily and credited to your account monthly. The interest rate will be reviewed periodically and is subject to change. To hear the current rate, please call our toll-free line, (800) 883-7190.

Account services are provided.

Benefit NOW is a special service we provide to you at no cost and functions similarly to your personal checking account. You will receive detailed monthly statements to help you track your balance, activity and credited interest. Fees apply only for services such as processing returned checks, stop-payment orders, and providing copies of canceled checks or statements.

Plan for the future, designate a beneficiary.

Your Bankers Benefit NOWAccount can provide for your heirs in the event of your death. You will receive a beneficiary designation form with your Benefit NOW Welcome Kit. Simply fill it in and return to us to designate a beneficiary.

Contact us with questions.

If you have questions about Bankers *Benefit* NOW, please call a customer service representative toll-free (800) 621-3724.

Any comments relative to tax consequences are made for general education and informational purposes only. The Bankers insurance companies and its representatives are not independent tax advisers. Before acting, you should seek tax advice based on your own situation and objectives, and on the applicable laws and practices of the appropriate jurisdiction. Such advice should be obtained from your own legal and tax advisers who are independent, qualified, and duly-licensed to practice in that jurisdiction.



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BANKERS LIFE AND CASUALTY COMPANY Life Claims Department - P.O. Box 1937 Carmel, Indiana 46082-1937 (800) 621-3724



Life Insurance Claim Filing Instructions

For life insurance claims, the following items are required:

- 1. A certified copy of the death certificate (only one is required regardless of the number of policies).
- 2. All pages of the original life insurance policies. If they cannot be located, please complete the Lost or Destroyed Policy statement located within the claim form.
- 3. A completed, signed claim form. If there are more beneficiaries than the form will accommodate, a separate form must be completed.

Special Instructions:

- If the designated primary beneficiary died before the insured died, we require:
 - o A photocopy of the primary beneficiary's death certificate
 - o The claim form, completed by the contingent beneficiary(ies)
- If an attorney-in-fact is filing on behalf of the designated beneficiary, we require:
 - o The claim form signed in the capacity of attorney-in-fact pursuant to a Power of Attorney
 - o A copy of the Power of Attorney must be provided
- If the beneficiary is the estate of the insured, we require:
 - O A completed claim form signed by the estate's legal representative, along with a copy of the appointment papers evidencing his/her appointment
 - o The estate's tax ID number (TIN)
 - o If an estate will not be opened, we require letters testamentary or a small estate affidavit or similar document(s) provided by the insured's local government indicating that an estate will not be opened
- If the beneficiaries are the children of the insured and have not been designated by name, we require:
 - o A list of all children, including their current mailing address, telephone number, date of birth and social security number. This document must be notarized.
- If the beneficiary is a minor, we require:
 - o Documentation evidencing the appointment of a guardian for the minor's estate
 - o If guardianship documents cannot be obtained, the company will work with the minor's parent or legal guardian to determine an alternate method of payment. Payment may be possible under the state's Uniform Transfers to Minors Act.
- If the policy is assigned to a funeral home or cemetery, we require:
 - o An assignment on company letterhead, signed by all beneficiaries and an officer of the company
 - o An itemized billing statement
- If the beneficiary is a trust or under a trust agreement, we require:
 - o A completed claim form, signed by the trustee(s)
 - o A complete copy of the trust agreement
 - o The trust's tax ID number (TIN)

For additional assistance, please call our customer service center at (800) 621-3724. For your convenience, please retain a photocopy of all documents. Claim forms and supporting documents may be mailed to:

BANKERS LIFE AND CASUALTY COMPANY Life Claims Department - P.O. Box 1937 Carmel, Indiana 46082-1937 BANKERS LIFE AND CASUALTY COMPANY Life Claims Department - P.O. Box 1937 Carmel, Indiana 46082-1937 (800) 621-3724



Beneficiary's Life Insurance Claim Form

The company does not waive any right nor admit any claims by furnishing this form. This form must be executed by the person or persons to whom the insurance is payable. A certified death certificate must accompany this form. Every question must be fully answered. If there is more than one beneficiary, each must complete and sign a claimant's statement.

- When insurance proceeds are payable to an estate, the claimant's statement must be executed by the administrator or executor and a certified copy of Letters Testamentary must be furnished.
- When insurance proceeds are payable to a minor, the claimant's statement must be executed by the guardian of the Minor Beneficiary's assets and a certified copy of Letters of Guardianship must be furnished.
- If any part of the proceeds of a policy is payable to children or to others of a designated class, a notarized affidavit must be furnished giving the name and date of birth of each and stating that the persons named in the affidavit constitute all of the class designated in the policy. If any person in the class has died, the affidavit must give the date and place of death.

A. Insured ar	nd policy information		· · · · · · · · · · · · · · · · · · ·
Policy number		Name of deceased	
All other know	n names and /or aliases for the	deceased	
Cause of death			
Date of death_		Place of death	
Date of birth_		Place of birth	
Is any interest if If yes, please at	in policy pledged or assigned? ttach a copy of the assignment	and provide the name and address of	f assignee.
Was the insure If yes, please p	d's death accidental?rovide date of the accident and	describe how and where the accident	
	e policy enclosed? ndicate why below and comple		☐ Yes ☐ No
Please provide	ry information the following information for		
		Address	
Phone	Date of Birth	Social Security No.	Relationship to Deceased
Name		Address	
Phone	Date of Birth	Social Security No	Relationship to Deceased
Name		Address	
	Date of Birth		Relationship to Deceased

C. Settlement

BLC-002 (08/08)

The Bankers BenefitNOW Account® is our primary method of paying insurance proceeds over \$5000. BenefitNOW is an interest bearing draft account. By simply writing a draft you have immediate access to your funds whenever you need them. BenefitNOW may not be available in all states or some products. If a BenefitNOW account cannot be established, a single check will be issued to you. Please see the enclosed BenefitNOW insert.

The undersigned unde from any and all claim	erstands and agrees that any insurance as by the undersigned.	proceeds payable u	nder this policy shall serve	as a release of the company
Date	Claimant's Signature	·	Print Claimant's Name	
		;		
D. Additional Fact				(0)
Complete this section	if: a) accidental death benefits are in	ivolved or b) policy	has been inforce fewer tha	in two (2) years.
'				
Deceased's Employe	ď	Deceased	's Occupation	
• •				
		.	. *** 1	
Employer Address_		Date Las	t Worked	· · · · · · · · · · · · · · · · · · ·
	<u> </u>			
City		State	ZIP	<u>'</u>
Name of Deceased's 1	Employer's Health Insurance Carrier			
TARRE OF DOCUMENT B	Employer s from morrane carrier			
When did deceased fi	irst complain of or give other indication	on of the fatal illnes	s?	
TYTICH GIG GCCCASCG II	ist complain of or give odder maround	<u> </u>		
Whan did deceased fi	irst consult a physician for the fatal ill:	ness?		
When the deceased in	inst consult a physician for the rate in			
During the past (5) ye	ears, did the deceased:	. 41		UVes UNO
a) receive treats	ment or counseling in connection with or more cigarettes?	i the use of alcohol	or arugs?	I es □ No
c) fly as a pilot	student or crew member on any type	of aircraft?		L Yes ∐No
If yes, was th	ne deceased a licensed pilot?	***********************************		Yes No
	dications prescribed by a physician?			Yes LINO
II yes, please	e indicate the name and address of the	drugstore where the	prescription was tined.	
		4 4 4		
Name		Address		
				•
Please prove name an	nd address of family physician			
Name		Address		
Please provide names	and addresses of all physicians or pra	actitioners who atter	ided the deceased during th	e past (5) years.
		Addused		
Name	Disease or condition	Address		
Name	Disease or condition	Address		
Date	Disease or condition			
Name		Address		<u></u>
Date	Disease or condition			.,,

Please provide	names and addresses of all hospitals or institutions where deceased was treated during the past (5) years.
Momo	Address
Date Admitted	Address
•	
Name	Address
Date Admitted	Disease or condition
	A 4.4
Name	Address
Date Admitted	Disease of condition
	and the second of the second o
Please provide	other life, health and accident insurance covering the deceased.
Сотрапу	Policy dated
Amount of ins	uranceBeneficiary
Company	Policy dated
Amount of ins	uranceBeneficiary
Comments	Policy dated
Amount of ins	Policy dated
f you do not kno Name Phone	w any of the requested information, please provide information on person(s) having this knowledge. Address Relationship to deceased
You are liable for I will be withheld what withheld, you and estimated tax protes. The electralien, you must check One:	Rederal/State income taxes on the taxable portion of your benefits. Unless you tell us otherwise, Federal/State income taxes there applicable. If you elect not to have withholding apply (where applicable) or if you do not have enough Federal income may be responsible for payment of estimated tax. You may incur penalties under the estimated tax rules if your withholding payments are not sufficient. Sign below may not be valid in those states that have mandatory withholding. Also, if you are a non-resident to complete form W-8BEN instead of making this election and completing the Taxpayer certification. a) I do not want Federal/State income tax withheld from my payment b) I do want Federal/State income tax withheld from my payment
Note: If you wis request if your : or state law.	h a specific amount or percentage to be withheld, please indicate in the spaces below. We will honor your state requires us to withhold state income tax and if your request does not conflict with applicable federal Specified Federal Tax Election \$or% Specified State Tax Election \$or%
Faxpayer Identific	ation Number: Social Security NumberOR EIN
CERTIFICATION-I	Under penalties of perjury, I certify that: shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me,) and
Internal Reve	ect to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the nue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) otified me that I am no longer subject to backup withholding.
3. 1 am a U.S. pe	erson (including a U.S. resident alien).
Note: Cross out have underrepo	t 2 above if you have been notified by the IRS that you are subject to backup withholding because you orted interest or dividends on your tax return.

F. Authorization

I hereby authorize any medical professional, hospital, or other medical-care institution, insurance support organization, governmental agency, insurance company, employer or other organization, institution or person that has any information, records or knowledge of the deceased's health to furnish to Bankers Life and Casualty Company or its representatives and permit them to examine and copy any information. I understand that such information will be used for the purpose of evaluating my claim for insurance benefits, and I acknowledge that I or my authorized representative have a right to a copy of this authorization upon request. A copy of this authorization shall be valid from the date signed for the duration of the claim or the term of the coverage.

H. For your protection, the laws of several states require the following statement:

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

AK, DE, RESIDENTS: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ RESIDENTS: 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.

AR RESIDENTS: 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 fines and confinement in prison.

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

CO RESIDENTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DC RESIDENTS: 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.

FL RESIDENTS: 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.

ID RESIDENTS: Any person who knowingly and with intent to defraud or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

IN RESIDENTS: A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

KY RESIDENTS: 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.

LA RESIDENTS: 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 fines and confinement in prison.

MN RESIDENTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NM RESIDENTS: 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.

ME, TN, VA RESIDENTS: 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 or a denial of insurance benefits.

NH RESIDENTS: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ RESIDENTS: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NY RESIDENTS: 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 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.

OH, OR RESIDENTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK RESIDENTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA RESIDENTS: 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.

PR RESIDENTS: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars no more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Life Insurance Form B. Authorization

(Page 1 of 1)

Bankers Life and Casualty Company
Life Division
600 West Chicago Ave
Chicago, IL 60654-2800
800-845-1604

BANKERS LIFE AND CASUALTY COMPANY AUTHORIZATION FOR CLAIM PROCESSING PURPOSES Pursuant to the HIPAA Privacy Rule §164.508(c)

I, the undersigned, authorize any licensed physician, medical practitioner, hospital, clinic, medical or medical related facility, the Veteran's Administration, insurance company, the Medical Information Bureau, Inc. (MIB), employer of Government agency to disclose personal information about me as described below.

This authorization was prepared by Bankers Life and Casualty Company for purposes of obtaining personal information necessary to process a claim for benefits. The information subject to this authorization is any and all information, including health information, requested by Bankers Life and Casualty Company for the purpose stated above as well as any information provided to them or their affiliated insurance companies on any previous applications. The information covered by the authorization does not include psychotherapy notes but does include any information about drug abuse, alcoholism, and mental illness. In addition, the information covered by the authorization does include any such information that has been restricted by my request.

Persons or entities employed by or authorized by Bankers Life and Casualty Company to perform tasks related to the claims process are hereby authorized to use the personal information covered by this authorization. I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information will likely no longer be protected by the federal privacy regulations and may be subject to redisclosure. However, I further understand that all such persons or entities have signed agreements to protect said information.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Bankers Life and Casualty Company, or, so long as Bankers Life and Casualty Company has a legal right to contest the coverage or a claim under the coverage. Revocation requests must be sent in writing to:

Bankers Life and Casualty Company Privacy Office 600 West Chicago Ave Chicago, IL 60654-2800

I understand that Bankers Life and Casualty Company cannot condition the payment of a claim on my signing this authorization. This authorization will expire upon the final action related to the claim for which this authorization is signed.

A copy of the authorization may be used in the place of the original. If this authorization is for someone other than myself, that individual and my authority to act on his/her behalf are explained below.

(Please Print) Name of Individual Whose Information is Covered By This Authorization	
Signature of Individual and Date	
(Please Print) Name of Representative with authority to act on behalf of Individual Who By This Authorization	ose Information is Covered
Relationship of Representative to Individual	
Signature of Representative and Date	