



HealthChoice Life Claim Department
P.O. Box 8009
Wausau, WI 54402-8009

On behalf of HealthChoice, please accept our sincere condolences during this difficult time.

Inside this packet you will find the forms and steps you need to submit your life insurance claim.

Forms in this packet:

- Life Insurance Claim Form.
- Electronic Funds Transfer Authorization.
- Funeral Home Designation.

Steps to submit your claim:

- 1. Decide** – You have the following options to receive your life insurance benefits:
 - Electronic funds transfer to your banking account (complete the enclosed Electronic Funds Transfer Authorization form).
 - A check that we mail to you.
- 2. Complete** – Complete the enclosed Life Insurance Claim Form; follow the instructions on the form. Please provide all the information requested so we may process your claim as quickly as possible. Missing or incorrect information could delay your claim.
- 3. Return** – Please send your completed claim form and additional documents to: HealthChoice Life Claim Department
P.O. Box 8009
Wausau, WI 54402-8009

What to expect after you submit your claim:

We are committed to processing your claim as quickly as possible. Once we receive all your information and verify benefits, we typically process a claim within 10 business days. If we approve your claim and you chose to receive a check, we will mail you the check. If you chose to receive your proceeds through electronic funds transfer, we will transfer the funds to the account designated on the EFT authorization form.

We recognize this may be a challenging time for you. If you have questions, or need help preparing your claim, please give us a call toll-free at 800-323-4314. Customer Care is available Monday through Friday, 7:30 a.m. to 6 p.m. Central time.

Sincerely,
HealthChoice Life Claim Team



LIFE INSURANCE CLAIM FORM

Use this form to submit your claim for a life insurance payment. Each potential beneficiary submitting a claim must complete and submit a separate claim form. For questions, please call Customer Care toll-free at 800-323-4314.

Section 1: Information about the deceased

First name Middle initial Last name

SSN Date of birth (mm/dd/yyyy) Date of death (mm/dd/yyyy)

Section 2: Information about the claimant

First name Middle initial Last name

Mailing address City State ZIP code

Phone Alt phone Date of birth

Section 3: Claim payment election (check one)

- I would like to receive my payment through electronic funds transfer. (This is a more safe, secure, efficient and expedient method to receive your funds.)
- I would like to receive my payment as a check via mail.

Section 4: Additional documentation checklist

- Death Certificate.** A final death certificate is required. Only one is needed. If you are aware of another claimant sending one, you do not need to send one.
- Electronic Funds Transfer Authorization.** If you would like your payment sent electronically to your bank account, complete and return the enclosed form.
- Funeral Home Designation.** If you would like to authorize payment directly to the funeral home, complete and return the enclosed form.
- Proof of accident.** If the deceased died in an accident and you are making an accidental death benefit claim, provide proof of the accident.
- Power of attorney.** If you have POA, provide a copy of the appointment papers naming you as attorney-in-fact for the beneficiary.

Section 5: Signature

By signing, I certify that all information provided above is true and complete to the best of my knowledge:

Claimant signature

Date

Section 6: HealthChoice member number

HealthChoice member ID



FUNERAL HOME DESIGNATION

Use this form to designate all or a portion of your life insurance payment, once approved, to the funeral home. For questions, please call Customer Care toll-free at 800-323-4314.

Section 1: Information about the deceased

First name Middle initial Last name

SSN Date of birth (mm/dd/yyyy) Date of death (mm/dd/yyyy)

Section 2: Information about the claimant

First name Middle initial Last name

Mailing address City State ZIP code

Phone Alt phone Date of birth

Section 3: Information about the funeral home

Name of funeral home Name of contact/representative

Street address City State ZIP code

Phone Tax ID number

Name of banking institution

Bank city/state Bank phone

Routing number Account number

Section 4: Authorized payment information

Authorized payment amount to funeral home

\$

Section 5: Signatures

Claimant signature Date

Witness signature Date

Section 6: HealthChoice member number

HealthChoice member ID



ELECTRONIC FUNDS TRANSFER AUTHORIZATION

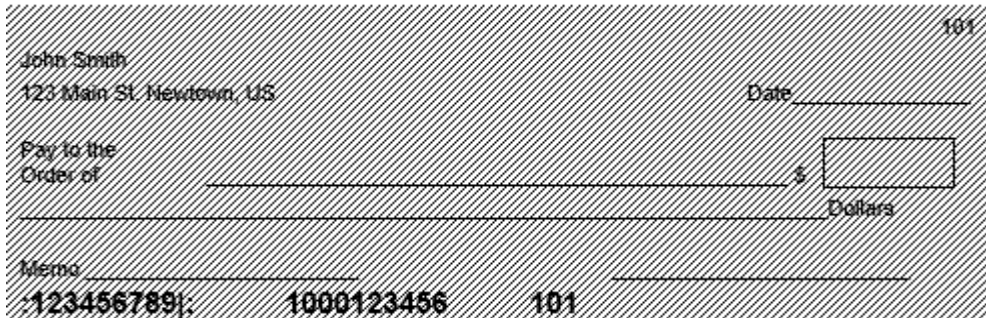
Use this form to authorize approved life insurance payments to be submitted to your financial institution through an electronic funds transfer. For questions, please call Customer Care toll-free at 800-323-4314.

First name			Middle initial	Last name	
Mailing address		City	State	ZIP code	
Phone	Alt phone		Date of birth		

Section 2: Banking information

Name of banking institution _____

Bank city/state	Bank phone
Routing number	Account number



▲ Routing Number ▲ Account Number

Section 3: Signatures

By signing, I certify that all information provided above is true and complete to the best of my knowledge:

Claimant signature	Date
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Section 4: HealthChoice member number

HealthChoice member ID _____