4 EVER LIFE INSURANCE COMPANY

Bay Bridge Administrators, LLC
P.O Box 161690
Austin, TX 78716
(800) 845-7519

EMPLOYER GROUP LIFE AND ACCIDENTAL DEATH CLAIM FORM

SECTION I Employer's Statement

Employee's Name | Employee's Birthdate | Employee's Social Security No.

Deceased's Name | Address (street, city, state, zip code)

4 Ever Life Insurance Group Policy | Certificate No.
Attach Group Certificate (unless dependent claim)

4 Ever Life Insurance Group Policy Effective Date for Employee: | Dependent:

Date to which premium is paid

Date Employed | Employee's Occupation

Was employee at work on above coverage effective date? ☐ Yes ☐ No

If not at work on effective date, when did Employee return to work?

Number of hours worked per week

Amount of Insurance
BASIC $ | SUPP $ | AD&D $

Amount of Salary $ | Per ☐ hour ☐ week ☐ month ☐ year | Effective date of salary

Date of Death | Date employee last reported for work

Reason for employee stopping work
☐ Deceased ☐ Illness ☐ Injury ☐ Retired Date: ____________
☐ Laid-off ☐ Terminated ☐ Vacation ☐ Other: ____________

I certify that the above information is correct based on our records. The information above and any accompanying documents and statements of all the physicians who attended or treated the deceased and all other papers required shall be part of the proofs of claim. The furnishing of this or any related form is not an admission that any insurance was in force on the date of death, nor a waiver of any rights or defenses.

Date | Name of Employer/Company | Signed By | Phone Number ( )

SECTION II Beneficiary's Statement

- If there is more than one beneficiary, **each beneficiary** must complete a copy of this section.
- **At least** one beneficiary must complete the Authorization Section.
- A **Certified copy** of the death certificate must be attached to the completed form.
- If claim is also made for **Accidental Death** benefits, beneficiary must complete the **reverse side**.

Beneficiary's Full Name | Address (street, city, state, zip code)

Relationship to Deceased | Social Security No. | Birthdate | Daytime Phone Number ( )

IMPORTANT TAX NOTICE FOR POLICYOWNER

Under Federal Tax law, the Company is required to ask you to certify your correct Taxpayer Identification Number (TIN) and to include it in any reports of taxable income it makes to the IRS. If you are an individual, your Social Security number is your Taxpayer Identification Number.

Certification: I certify that I am not subject to back withholding (Section 3406(a)(1)(c) of the Internal Revenue Code), and I am a U.S. person (including a U.S. resident alien). I also certify that the Taxpayer Identification Number on this form is true, correct and complete.

The Internal Revenue Service does not require your consent to any provisions of this document other than the certifications required to avoid backup withholding.

Beneficiary's Signature | Date

SECTION III Authorization

To physicians, hospitals, medical service providers, druggists, employers, consumer reporting agencies, law enforcement agencies, and any other agencies or organizations (including other insurance companies, Blue Cross-Blue Shield, self insured, and prepaid health plans) and specifically

____________ Hospital(s), and Dr.(s) ____________

You are authorized to permit 4 Ever Life Insurance Company and it's authorized representatives to view and obtain a copy of ALL RECORDS including employment, law enforcement, financial, insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric, drug or alcohol treatment and disease of

____
Print Name of Insured

I understand the information obtained will only be used by 4 Ever Life Insurance Company to determine eligibility for insurance and benefits claimed under the Insured's policy. I consent to redisclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my written consent.

I understand this authorization may be revoked by written notice to 4 Ever Life Insurance Company but this will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below.

I know I may request a copy of this authorization. I also agree a photographic copy of this authorization shall be as valid as the original.

Date | Signed | If other than insured, give relationship:

(OVER)

SECTION IV

Beneficiary's Statement For Employee Accidental Death

Please attach any newspaper articles, accident reports, autopsy report, and other documentation to support your claim.
Also, please provide the following information:

Insured's Name	Insured's Address (street, city, state, zip code)

Insured's Occupation at Time of Death	Date of Employment at This Place

Date and Time of Accident Causing Death	Date and Time of Death	Place of Accident
A.M. P.M.	A.M. P.M.	☐ At Work ☐ Recreation ☐ Other ☐ Highway ☐ Home ☐ ______

Describe Accident in Detail

Give Names and Addresses of Witnesses (attach separate sheet if necessary)

If automobile accident, was insured ☐ Driver of Vehicle ☐ Passenger ☐ Pedestrian

Did this accident occur in the course of the Insured's usual occupation? ☐ Yes ☐ No

If yes, has worker's compensation claim been presented? ☐ Yes ☐ No

What injuries were sustained?

Was immediate first aid sought? ☐ Yes ☐ No

If "Yes," give name and address of:

Doctor: ______

Hospital: ______

Other: ______

Was accident reported to police or other official agency? ☐ Yes ☐ No

If "Yes," give name and address of department or agency

Was an autopsy performed? ☐ Yes ☐ No

If copy **NOT** attached, complete below:

Autopsy Performed By	Address (street, city, state, zip code)	Date Performed

Names and addresses of all physicians or practitioners who treated insured in last 3 years

Name	Address (street, city, state, zip code)	Date Treated	Condition Treated

With what companies and in what amounts was life of deceased insured?

Name of Company	Policy Date	Amount	Accidental Death Benefits
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Beneficiary's Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

The laws of some states require us to furnish you with the following notices:
WARNING: Any person who knowingly:
Oklahoma: 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.
Texas: presents a 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.