EagleAmerican
Life Insurance Company

Life/ Accidental Death Claim Form

Please complete pages 1 and 2 and return to us.

Contact Us:
PO Box 584
Marksville, LA 71351-0584
318-240-8696

Section One - Personal Information For Insured - Completed By Financial Institution Or Estate Representative

Insured first name and middle initial		Last Name	
Street address		Apt. no.	City, state and zip code
Birth Date	Last 4 digits of insured's Social Security #	Phone number (include area code) ( ) -	

Section Two - Life or Accidental Death Information - Completed By Financial Institution Or Estate Representative

Cause of death due to: Sickness ☐ Accident ☐		Policy, certificate or loan number(s)	
Name of treating physician at death, their clinic or hospital name and phone number			
Name of personal physician for insured (provider of most of insured's medical care), their clinic name and phone number			
Name of insured's administrator of estate or spouse		Phone number (include area code) ( ) -	
Street address of insured's administrator of estate or spouse		Apt. no.	City, state and zip code

Section Three - Certification and Signature - Completed By Estate Representative

By signing below, I certify that: (1) the above statements are complete and accurate to the best of my knowledge (2) I was given a copy of Eagle American Life Insurance Company's "Information Notice" document.

Signature X Date signed X

Any person who knowingly and with intent to defraud, files a statement of claim containing any materially false or misleading information, commits a fraudulent act which is a crime.

EagleAmerican
Life Insurance Company

Authorization To Collect And Disclose Information

Contact Us:
PO Box 584
Marksville, LA 71351-0584
318-253-9612

Section Four - Authorization To Collect And Disclose Information

I understand Eagle American Life, its reinsurers, and all persons or companies authorized to represent these parties may obtain **Information** (described below) about the patient named below as allowed or required by law from a **Source** (described below) in order to evaluate a claim for life insurance benefits with Eagle American Life Insurance Company. I authorize any Source(s) to disclose or release Information to Eagle American Life Insurance Company, P.O. Box 584, Marksville, LA 71351-0584 or its authorized representative when this Authorization is presented. I affirm that I am legally allowed to sign for the release of such medical information

Information is defined as facts about the patient named below. It includes facts about these topics; mental and physical health, including facts about communicable or sexually transmitted diseases such as HIV infection, AIDS, Hepatitis and Syphilis; prescription drug records; tobacco, drug and alcohol use; other insurance coverage; employment; character; general reputation; mode of living; finances; vocation; and other personal traits. **It does not include facts about sexual orientation or psychotherapy notes.**

Source is defined as medical physicians; chiropractors; physical therapists; psychologists; drug, alcohol or mental health counselors; hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; insurers; reinsurers; consumer reporting agencies; financial sources; employers; the Social Security Administration; neighbors; friends; and relatives.

I Acknowledge That:

The purpose for the release of Information is to allow Eagle American Life Insurance Company to make a claims decision regarding payment of possible life insurance claim benefits and/ or to resolve any issues of incorrect or misrepresented information that may have originally been provided on an application for insurance with Eagle American Life Insurance Company.

I understand that any Information disclosed pursuant to this Authorization may no longer be covered by federal rules concerning privacy and confidentiality of personal information, but it will not be redisclosed by the recipient except as authorized by me or as allowed by law. Consumer Reporting Agencies may disclose Information only as set forth in an agreement with a member company or organization. Certain laws may pertain to some kinds of Information and may further restrict disclosure of that Information.

Any agreements that may have been made to restrict the patient's Information do not apply to this Authorization and I instruct any Source to release and disclose the entire contents contained in the patient's Information file to Eagle American Life Insurance Company without restrictions and to the limits allowed by law. Information may be transmitted via U.S. regular mail, various other land or air mail services and through the use of secured electronic devices.

This Authorization will remain in effect for 12 months from the date it is signed by me; that a copy is a valid as the original and that I am entitled to a copy of this Authorization upon request. I further understand I may revoke this Authorization by sending a written request to Eagle American Life Insurance Company at the address listed above and that it will become effective when received by them. Any action already taken in reliance on this Authorization cannot be reversed and my revocation will not affect those actions.

I understand that a medical provider to whom this Authorization is submitted may not condition its treatment of the patient on whether or not I sign this Authorization. I further understand that if I refuse to sign this Authorization, Eagle American Life Insurance Company may not be able to make life insurance benefit payments.

I may request and receive a copy of the Information described on this form by submitting a written request to Eagle American Life Insurance Company at the address listed above.

Personal Representative signature (required)	Relationship to Patient (required)	Date signed (required)
X	X	X
Patient name (required)	**Patient date of birth (required)**	**Patient Social Security Number (required)**
X	X	X

This form may be signed by someone who is either the surviving spouse, administrator of the estate or someone who has power of attorney for the patient's legal affairs. Legal documentation should be included for anyone other than the spouse.

EagleAmerican
Life Insurance Company

Information Notice

This document is for your information.
Please do not submit with pages 1 and 2

Contact Us:
PO Box 584
Marksville, LA 71351-0584
318-240-8696

Section Five - Information Notice - To Be Read And Kept By Estate Representative

Our Commitment to Our Customers

Eagle American will act as quickly, fairly and compassionately as possible on your claim for Life and/ or Accidental Death insurance benefits. We know that loss of a loved one is stressful. To assist us in doing this, please be sure that the claim form is properly and completely filled out before submitting it to us. Wrong information or no information on the claim form will cause us to send it back to you for corrections. Should you have any questions, please feel free to contact us at the phone number or address listed above.

Your Claim Responsibilities

You must provide us with a truthful and accurate claim form and any other reasonably necessary information or documents that will assist us in processing the claim accurately. Please be advised that you may be violating state law if you knowingly conceal material facts or submit a claim form that contains materially false information. You have the right to decline to provide Eagle American with the requested information or documents, but Eagle American has the right to discontinue processing of your claim if you choose to deny us access to information that is reasonable and necessary to process the claim.

Processing Time and Payment of Claims

If the insurance certificate or policy is less than two years old, please allow up to eight weeks for processing time. If the insurance certificate or policy is more than two years old, please allow up to three weeks for processing time. We will correspond with you at least once every three weeks and keep you informed. Payment of claims is made directly to the financial institution unless the loan has been fully repaid or the financial institution directs us to do so.

If any payments were made after the date of death, they will be accounted for and returned upon payment by us. Many times, there will be benefits paid that exceed the amount of the loan. In this case, we will make payment of the excess benefits to either the spouse or the insured's estate. Late fees may contractually still be charged to the loan by the financial institution.

Contestability of Coverage and Exclusions of Coverage

Because the original application for insurance was most likely our primary source of information in accepting coverage, we may conduct a review of the accuracy of the insured's answers on the application when we receive the completed claim form (if the claim is filed within two years after taking coverage out). If, upon review, materially incorrect health information is found on the application, the claim may be denied and coverage may be considered void as of the Effective Date. In this situation, we will refund 100% of the premium and provide you with a complete description of what information we relied upon in making our decision. Also, we may verify whether or not the cause of death is a result of an occurrence that fell within the exclusions contained within the policy or group certificate. If the cause of death is not covered due to an exclusion contained within the policy or group certificate, the claim may be denied and coverage may be considered void as of the Effective Date. In this situation, we will refund 100% of the premium and provide you with a complete description of what information we relied upon in making our decision. Please read the "Exclusions" area of the policy or certificate for more information. If you do not have a copy of the policy or certificate, we will provide one for you at no charge upon your request.

Our Information Practices

We will rely primarily on information provided by the insured on the application for insurance, physician(s) that may have knowledge of the insured's health that is material to making a claims decision and the death certificate. On occasion, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. In certain limited situations, we are allowed by law to disclose necessary items of personal information about the insured to third parties without your specific authorization.