



Transamerica Life Insurance Company  
Transamerica Premier Life Insurance Company  
P.O. Box 8043  
Little Rock, AR 72203-8043  
Phone: 800-251-7254 (7:00 a.m. – 5:00 p.m. CST)  
Fax: 866-586-6528

Death  
Claim  
Form

| Decedent's Information                                                                                                                          |                   |                         |         |                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------|---------|-----------------------|
| 1. Name in Full                                                                                                                                 |                   | 2. Social Security No.  |         | 3. Policy No.         |
| 4. Date of Birth                                                                                                                                | 5. Street Address |                         | 6. City | 7. State              |
|                                                                                                                                                 |                   |                         |         | 8. Zip Code           |
| 9. Employer's Name                                                                                                                              |                   |                         |         |                       |
| 10. Street Address                                                                                                                              |                   | 11. City                |         | 12. State             |
|                                                                                                                                                 |                   |                         |         | 13. Zip Code          |
| 14. Date Last Worked                                                                                                                            |                   | 15. Occupation at Death |         |                       |
| 16. Date of Death                                                                                                                               |                   | 17. Place of Death      |         | 18. Cause of Death    |
| 19. Name of all physicians or practitioners who attended decedent within five years preceding death: <i>(attach additional sheet if needed)</i> |                   |                         |         |                       |
| Name                                                                                                                                            |                   | Address                 |         | Date of attendance    |
|                                                                                                                                                 |                   |                         |         | Diseases or condition |
|                                                                                                                                                 |                   |                         |         |                       |
|                                                                                                                                                 |                   |                         |         |                       |
|                                                                                                                                                 |                   |                         |         |                       |

| Claimant's Information                                                                                                                                                                                                                                                    |  |                                        |          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------|----------|
| 1. Name in Full                                                                                                                                                                                                                                                           |  | 2. Social Security No.                 |          |
|                                                                                                                                                                                                                                                                           |  | 3. Date of Birth                       |          |
| 4. Daytime Phone Number                                                                                                                                                                                                                                                   |  | 5. Evening Phone Number                |          |
|                                                                                                                                                                                                                                                                           |  |                                        |          |
| 6. Are you subject to backup withholding? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(see instruction # 8 for more information on taxes)</i><br>I certify that this is my correct tax reporting number, and that I am not subject to backup withholding. |  |                                        |          |
| Signature                                                                                                                                                                                                                                                                 |  | Date                                   |          |
| This claimant made claim to the insurance and agrees that by furnishing this form, the Company does not admit that any insurance was in force on the life of the deceased and does not waive any of its rights or defenses.                                               |  |                                        |          |
| Signed in (City/State)                                                                                                                                                                                                                                                    |  | This _____ Day of (Month/Year) _____ . |          |
| Signature                                                                                                                                                                                                                                                                 |  | Relationship to deceased               |          |
| Address                                                                                                                                                                                                                                                                   |  | City                                   | State    |
|                                                                                                                                                                                                                                                                           |  |                                        | Zip code |

The information above is true and correct to the best of my knowledge.

\_\_\_\_\_  
Claimant's Signature

\_\_\_\_\_  
Date

| <b>Employer's/Business Entity's Statement</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                                               |                                                                                                                          |                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| 1. Decedent's Name in Full                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2. Decedent's Age                             | 3. Employee's/Insured Person's Name                                                                                      | 4. Employee's/Insured Person's Social Security No.                |
| 5. Name of Company                                                                                                                                                                                                                                                                                                                                                                                                                                           | 6. Group Policy No.                           | 7. Employee/Insured Person was<br><input type="checkbox"/> Salaried <input type="checkbox"/> Hourly                      | 8. Employee's/ Insured Person's annual salary as per date of loss |
| 9. Date Insured (employee/insured person)                                                                                                                                                                                                                                                                                                                                                                                                                    | 10. Date Insured (dependent)                  | 11. Date of Hire                                                                                                         | 12. Last date Employee/Insured person worked                      |
| 13. Employee's/Insured Person's status as of last date worked:<br><input type="checkbox"/> Active <input type="checkbox"/> Vacation <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Laid Off<br><input type="checkbox"/> Terminated <input type="checkbox"/> Retired<br>If other than Active, Please explain: _____                                                                                                                       |                                               |                                                                                                                          | 14. Date employee/insured person returned to work:                |
| 15. Did injury occur on duty<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                     | 16. If "Yes", give date of injury and details |                                                                                                                          |                                                                   |
| 17. Amount of Insurance                                                                                                                                                                                                                                                                                                                                                                                                                                      | 18. Amount of Claim                           | 19. Was premium paid and insurance in force at time of loss?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                   |
| Signed in (City/State) _____ This _____ Day of (Month/Year) _____.<br><br><div style="display: flex; justify-content: space-between;"> <div>_____<br/>Printed Name of Authorized Representative</div> <div>_____<br/>Signature of Authorized Representative</div> <div>_____<br/>Official Title</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div>Phone Number _____</div> <div>Fax Number _____</div> </div> |                                               |                                                                                                                          |                                                                   |

## REQUIRED FRAUD WARNING STATEMENTS

Claimants are required to acknowledge receipt of fraud warnings. Please refer to the fraud warning statement for your state as indicated below. Sign, date, and return with claim documents.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>FOR RESIDENTS OF ALASKA or TEXAS:</b> A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, or misleading information may be prosecuted under state law.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>FOR RESIDENTS OF MAINE, TENNESSEE or VIRGINIA:</b> It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>FOR RESIDENTS OF ARIZONA:</b> 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>FOR RESIDENTS OF MARYLAND:</b> Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>FOR RESIDENTS OF CALIFORNIA:</b> 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 be subject to fines and confinement in state prison.                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>FOR RESIDENTS OF MINNESOTA:</b> A person who files a claim with intent to defraud or help commit a fraud against an insurer is guilty of a crime.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>FOR RESIDENTS OF COLORADO:</b> 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 the insurance proceeds shall be reported to the <u>Colorado Division of Insurance</u> within the department of regulatory agencies. | <b>FOR RESIDENTS OF NEW HAMPSHIRE:</b> 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 by RSA 638:20.                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>FOR RESIDENTS OF DELAWARE, IDAHO, INDIANA or OKLAHOMA:</b> Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>FOR RESIDENTS OF NEW YORK:</b> 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 act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.                                                                                                                                                                                                                                                         |
| Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>FOR RESIDENTS OF DISTRICT OF COLUMBIA, LOUISIANA or RHODE ISLAND:</b> Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>FOR RESIDENTS OF PUERTO RICO:</b> Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years. |
| Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>FOR RESIDENTS OF FLORIDA:</b> 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>FOR RESIDENTS OF ALL OTHER STATES AND TERRITORIES:</b> Any person who knowingly, and with intent to injure, defraud or deceive 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.                                                                                                                                                                                                                                                                                  |
| Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>FOR RESIDENTS OF HAWAII:</b> For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Claimant's signature _____ Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |



Name of Insurance Company (select one):

- ☐ Transamerica Life Insurance Company  
☐ Transamerica Premier Life Insurance Company

If no Company is selected, the appropriate box will be checked by the Administrative Office.

Administrative Office: P.O. Box 8043  
Little Rock, Arkansas 72203-8043

### AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of health information about the Insured as described below and revoke any previous restrictions concerning access to such information:

- Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any physician, medical practitioner, hospital, clinic, pharmacy, long-term care facility, nursing home, assisted living facility, home health care entity, medical or medically-related facility, laboratory, and insurance company (including the Company selected above), or other organization, institution or person having records or knowledge of the Insured's health.
- Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** the Company noted above, its affiliates, its reinsurers, their agents or other representatives, and business associates.
- Description of the information that may be used or disclosed:** This authorization relates to the release of any medical records necessary to evaluate and determine the Insured's eligibility for benefits, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse information, or information regarding AIDS. **Exception: psychotherapy notes require a separate signed authorization.**
- The information will be used or disclosed only for the following purpose(s):** The requested information will be used for any claim processing purposes, including but not limited to determining the Insured's benefit eligibility and making benefit determinations.

### STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that the Insured's eligibility for benefits may be affected if I refuse to sign this form. In that case, the Company may not be able to determine if the Insured qualifies for benefits.
- I understand that the Insured has a right to receive the HIPAA Notice of Health Information Privacy Practices that explains the Company's privacy practices (not applicable to life, accident or disability insurance policies).
- I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment or health care operations.
- This authorization shall be valid for as long as claims continue under the policy, and I understand I am entitled to a signed copy.
- A copy of this authorization will be considered as valid as the original.
- I acknowledge that I have received a copy of this authorization.

Patient/Insured's Name/Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient/Insured's SSN \_\_\_\_\_ Patient/Insured's Date of Birth \_\_\_\_\_ Patient/Insured's Phone No. \_\_\_\_\_

Patient/Insured's Address \_\_\_\_\_

Personal Representative's (if any) Name/Signature: \_\_\_\_\_ Personal Representative's Phone No. \_\_\_\_\_

Personal Representative's (if any) Address \_\_\_\_\_

Description of Personal Representative's Authority or Relationship to Patient/Insured \_\_\_\_\_

Policy or Contract Number \_\_\_\_\_

**Claimant should retain a copy of this signed document for their records**