



HELPING PROTECT WHAT MATTERS MOST

A step-by step guide for
submitting a life insurance claim

Transamerica Life Insurance Company is committed to a streamlined claims process, with a primary goal of eliminating unnecessary rounds of paperwork and phone calls.

THIS CLAIM PACKAGE MAKES IT SIMPLER

The attached Basic Life Claim Package (for a claim with a non-contestable, individual beneficiary) includes the four following documents:



Claimant's Statement



Employer/Business
Statement



Required Fraud
Warning Statements



Authorization for the
Release of Health
Information

STEP-BY-STEP FILING PROCESS

Here's how to get the claim started:

- 1 The beneficiary completes the Claimant Statement form. If there is more than one beneficiary, each should complete a Claimant Statement form. If you need additional forms, please use photocopies of the original.
- 2 Please provide all information requested or write NA (for "Not Applicable") on lines you intend to leave blank. If you need additional space for any answer, you may add additional pages.
- 3 Please know that you pay costs for the claim, including fees for death certificates or legal documents that may be needed.
- 4 If the policy has been in force for fewer than two years or was reinstated in the past two years, we will send you a medical provider list and authorization form to complete.

Once the employer has gathered all of the completed forms mentioned above, a copy of the application/enrollment card and any beneficiary change forms (if applicable) also need to be attached before sending to Transamerica and for processing to begin.

With all required documentation and complete, legible, signed forms, Transamerica typically processes claim benefits within four (4) business days — which can provide a little comfort during a chaotic and challenging time.

WHAT MIGHT REQUIRE EXTRA TIME TO PROCESS

- Incomplete, unreadable, or unsigned claim forms
- We receive the claim within two years of the signed insurance application
- The policy lapsed and was reinstated within two years of the date of death (for which we request a medical provider list to obtain medical records)
- The insured didn't name a beneficiary or if the beneficiary is no longer living
- The beneficiary is a minor, legally incapacitated person, or a trust
- Benefits are payable to the estate of the insured or policy owner
- The insured died outside the United States
- The insured was a victim of homicide



We're here to help.

Here's how to get in touch with any questions:



CALL

855-244-8318



EMAIL

selfadminclaims@transamerica.com



FAX

866-586-6528



HOURS

Mon – Thu: 7 a.m. to 5:30 p.m. CT

Fri: 7 a.m. to 5 p.m. CT

TCS e-Serve International Limited (Tell) is a third-party administrator for Transamerica Life Insurance Company and Transamerica Financial Life Insurance Company. Tell and Transamerica are not affiliated in any way.

Insurance products **underwritten by Transamerica Life Insurance Company (TLIC)**, Cedar Rapids, IA. TLIC is authorized to conduct business in all other states.

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TRANSAMERICA®



Transamerica Life Insurance Company
Transamerica Financial Life Insurance Company
P.O. Box 869094 Plano, TX 75086-9094
Phone: 855-244-8318
Fax: 855-604-5205

Death Claim Form
SELF-ADMIN

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		

Claimant's Information

1. Name in Full		2. Social Security No.		3. Date of Birth	
4. Daytime Phone Number			5. Evening Phone Number		
6. Email address:					
7. Are you subject to backup withholding? ☐ Yes ☐ No (see instruction # 11 for more information on taxes) 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 affirm 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		
Mailing Address		City		State	Zip code
Street Address		City		State	Zip Code

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

Claimant's Signature

Date



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Employer's/Business Entity's Statement			
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 ☐ Salaried ☐ Hourly	8. Employee's/ Insured Person's annual salary as of the date of loss
9. Date Insured (employee/insured person)	10. Date Insured (dependent)	11. Date of Hire	12. Last date Employee/Insured person actively worked
13. Employee's/Insured Person's status as of last date worked: ☐ Active ☐ Vacation ☐ Leave of Absence ☐ Laid Off ☐ Terminated ☐ Retired If other than Active, Please explain: _____			14. Date employee/insured person returned to work:
15. Did injury occur while at work? ☐ Yes ☐ 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? ☐ Yes ☐ No	
Signed in (City/State) _____ This _____ Day of (Month/Year) _____ .			
Printed Name of Authorized Representative		Signature of Authorized Representative	Official Title
Phone Number _____		Fax Number _____	

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.

FOR RESIDENTS OF ALASKA: 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. _____ Claimant's signature _____ Date	FOR RESIDENTS OF NEW HAMPSHIRE: 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
FOR RESIDENTS OF ARIZONA: 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. _____ Claimant's signature _____ Date	FOR RESIDENTS OF NEW YORK: 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 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
FOR RESIDENTS OF CALIFORNIA: 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. _____ Claimant's signature _____ Date	FOR RESIDENTS OF NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. _____ Claimant's signature _____ Date
FOR RESIDENTS OF COLORADO: 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 Colorado Division of Insurance within the department of regulatory agencies. _____ Claimant's signature _____ Date	FOR RESIDENTS OF OHIO: 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. _____ Claimant's signature _____ Date
FOR RESIDENTS OF DELAWARE, IDAHO, INDIANA or OKLAHOMA: 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. _____ Claimant's signature _____ Date	FOR RESIDENTS OF OREGON: Any person who knowingly and with intent to defraud an insurance company files an application for insurance or statement of claim containing any materially false information may be guilty of insurance fraud. To deny a claim on the basis of misstatements, misrepresentations, omissions or concealments, the mis-information must be material to the content of the policy, the insurer relied upon the mis-information and the information was either material to the risk assumed by the insurer or provided fraudulently. Misstatements, misrepresentations, omissions or concealments are not fraudulent unless they are made with the intent to knowingly defraud. _____ Claimant's signature _____ Date
FOR RESIDENTS OF DISTRICT OF COLUMBIA or LOUISIANA: 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. _____ Claimant's signature _____ Date	FOR RESIDENTS OF PENNSYLVANIA: 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 a person to criminal and civil penalties. _____ Claimant's signature _____ Date
FOR RESIDENTS OF FLORIDA: 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. _____ Claimant's signature _____ Date	FOR RESIDENTS OF PUERTO RICO: 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 payment of a loss or any other benefit, or presents more than one 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 \$5,000 and not more than \$10,000, or a fixed term of imprisonment for 3 years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of 5 years, if extenuating circumstances are present, it may be reduced to a minimum of 2 years. _____ Claimant's signature _____ Date
FOR RESIDENTS OF MAINE, TENNESSEE or WASHINGTON: 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	FOR RESIDENTS OF VIRGINIA: Any person who, with the 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 may have violated the state law. _____ Claimant's signature _____ Date
FOR RESIDENTS OF MARYLAND, RHODE ISLAND, TEXAS or WEST VIRGINIA: 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	FOR RESIDENTS OF ALL OTHER STATES AND TERRITORIES: 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
FOR RESIDENTS OF MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. _____ Claimant's signature _____ Date	



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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:

1. **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.
2. **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.
3. **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.**
4. **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