Essential StaffCARE

Mail claims to:
PAI, P.O. Box 6702, Columbia, SC 29260-6702

Accidental Loss of Life Claim Form

Section 1. Employer's Statement

Employee's Name: _____
Last First Middle

Employee's Birth Date: _____ Employee's SSN: _____

Address: _____
Street City State ZIP

Deceased's Name: _____
Last First Middle

Date of Death: _____ Deceased's Relationship to Employee: _____

BCS Insurance Company Group Policy Number: _____ Certificate Number: _____
Attach Group Certificate (unless dependent claim)

BCS Insurance Company Group Policy Effective Date for Employee: _____ Date to which premium is paid: _____

Dependent: _____

Date Employed: _____ Employee's Occupation: _____

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

Amount of Salary: $ _____ Per ☐ hour ☐ week ☐ month ☐ year

Date employee last reported for work: _____

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

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.

Name of Employer/Company: _____ Telephone: _____

Signed by: _____ Date: _____

Section 2. Beneficiary's Statement

- If there is more than one beneficiary, each beneficiary must complete a copy of this section.
- A certified death certificate must be attached to the completed form.
- If claim is also made for Accidental Loss of Life benefits, beneficiary must complete Section 4.

Beneficiary's Full Name: _____ SSN: _____
Last First Middle

Address: _____
Street City State ZIP

Birth Date: _____ Daytime Telephone: _____ Relationship to Deceased: _____

Important Tax Notice for Policy Owner

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.

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by BCS Insurance Company
Oakbrook Terrace, Illinois

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.625.20220728

Certification: I certify that I am not subject to backup 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 3. Authorization

Authorization Instructions: The authorization should be completed and signed by the insured. If the insured is unable to sign, the authorization should be completed and signed by the legal guardian or next-of-kin.

To healthcare providers:

You are authorized to permit Planned Administrators, Inc., its Third Party Administrators, and any authorized representative to view and obtain copies of all records related to health care services rendered, health care advice, treatment or supplies provided to the patient including information related to mental illness, drug or alcohol treatment, HIV or AIDS. The information provided will only be used as it relates to the evaluation of claims for benefit payment.

I understand the information obtained will only be used by Planned Administrators, Inc. to determine eligibility for insurance and benefits claimed under the policy. I consent to disclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organization 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 consent. I understand this authorization may be revoked by written notice to Planned Administrators, Inc. but this revocation 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 to receive a copy of this authorization. I also agree that a photographic copy of this authorization shall be as valid as the original.

_____ _____ _____
Employee Signature | Date | Relationship to insured if signed by other than insured.

(If signed by other than the Insured, please print name and address and include guardianship papers or other evidence of legal representation.)

_____ _____
Name | Address

Section 4. Beneficiary's Statement for Insured's Accidental Loss of Life.

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: _____
Last First Middle

Insured's Address: _____
Street City State ZIP

Insured's Occupation at Time of Death: _____ Date of Employment at this Place: _____

Date and Time of Accident Causing Death: _____ _____ ☐ A.M. ☐ P.M.

Date and Time of Death: _____ _____ ☐ A.M. ☐ P.M.

Place of Accident: ☐ At Work ☐ Recreation ☐ Highway ☐ Home ☐ Other: _____

Describe Accident in Detail: _____

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

Name *Address*

_____ _____

_____ _____

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 workers' 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 yes, please attach a copy of the report.

Autopsy performed by: _____ Date of Performed: _____

Address: _____
Street City State ZIP

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

Name	*Address (Street, City, State, ZIP)*	*Date Treated*	*Condition Treated*

Beneficiary's Signature: _____ Date: _____

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ESC
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Accidental Loss of Limb or Sight Claim Form

By furnishing this form and investigating the claim, the Company does not admit liability and does not waive its rights or defenses.

Section 1. TO BE COMPLETED BY EMPLOYER OR PLAN ADMINISTRATOR

BCS Insurance Company Group Policy Number:	Certificate Number:	Social Security Number:

Claim is for: ☐ Employee ☐ Member ☐ Dependent	Name:	Relationship to Insured:

Insured's Name:	Job Title:	Last Date at Work:

Address:	Date of Birth Month Day Year

Insurance Classification	Effective date of last increase in benefits	Has insurance been terminated? ☐ Yes ☐ No	If "Yes," give date:

Full amount of Accidental Loss of Limb or Sight Insurance	Amount of this Claim	
$	$	☐ 100% ☐ 50%

Is loss due to an occupational accident? ☐ Yes ☐ No	If "Yes," has Workers' Compensation claim been filed? ☐ Yes ☐ No

Name of Workers' Compensation carrier:	Address:

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 claimant 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 loss of limb or sight, nor a waiver of any rights or defenses.

Employer/Plan Administrator _____ Address _____

Phone No. _____ Ext. _____

_____
City *State* *Zip Code*

Date _____ Email _____

By _____ _____
Title and Printed Name of Authorized Representative (required) *Signature of Authorized Representative (required)*

Section 2. TO BE COMPLETED BY EMPLOYEE, MEMBER OR DEPENDENT

Date of Accident:	Hour of Accident: ☐ A.M. ☐ P.M.	Place of Accident:

Describe what happened:	What injuries were sustained?

Was immediate First Aid sought? ☐ Yes ☐ No If "Yes," please list below:

Name and Address of Doctor	Name and Address of Hospital	Name and Address of Other Medical Facility

Was accident reported to police or other official agency? ☐ Yes ☐ No	If "Yes," name and address of official agency:

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Name and address of witnesses:		
Do you have other insurance providing loss of limb or loss of sight benefits? ☐ Yes ☐ No	If "Yes," name of other carrier:	Policy No.:
Name of auto insurance carrier, if loss is due to auto accident:		
Date	Signature of Employee, Member, or Dependent	

Section 3. AUTHORIZATION – MUST BE SIGNED BY EMPLOYEE, MEMBER OR DEPENDENT

Instructions: The authorization should be completed and signed by the Employee, Member, or Dependent. If the Employee, Member, or Dependent is unable to sign, the authorization should be completed and signed by the legal guardian or next-of-kin.

To healthcare providers:
You are authorized to permit Planned Administrators, Inc., its Third Party Administrators, and any authorized representative to view and obtain copies of all records related to health care services rendered, health care advice, treatment or supplies provided to the patient including information related to mental illness, drug or alcohol treatment, HIV or AIDS. The information provided will only be used as it relates to the evaluation of claims for benefit payment.

I understand the information obtained will only be used by Planned Administrators, Inc. to determine eligibility for insurance and benefits claimed under the policy. I consent to disclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organization 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 consent. I understand this authorization may be revoked by written notice to Planned Administrators, Inc. but this revocation 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 to receive a copy of this authorization. I also agree that a photographic copy of this authorization shall be as valid as the original.

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.

Date:	Signed:	Relationship to Insured if signed by other than Insured:

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Fraud Notices

Alabama: 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 restitution fines or confinement in prison, or any combination thereof.

Alaska: ALASKA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly and with intent to injure, defraud, or receive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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. Penalties may include imprisonment, fines, denials of **insurance** and civil damages.

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.

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 insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and 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.

District of Columbia: **WARNING**: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: 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 of the third degree.

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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 in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

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 person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Tennessee, Virginia and 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.

All Other States Not Listed Separately: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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