Guide to Making Your Life Insurance Claim

GREAT SOUTHERN
LIFE INSURANCE COMPANY

We are deeply sorry for your loss and extend our heartfelt condolences. We understand this is a difficult time, and we're committed to handling your claim with care and compassion. To support you, we've provided helpful resources at greatsouthern.com/claims, where you can also submit questions. If you need additional assistance, please call us at 816.908.3000 and follow the prompts provided. Thank you for allowing us to support you during this time.

***This form is for deaths that occur within the U.S., for foreign deaths or if the beneficiary lives outside the U.S., visit https://www.greatsouthern.com/SiteCollectionDocuments/ForeignClaim.pdf to complete your claim process.**

Claimant and Policy Information:
To submit a claim for life insurance, follow these steps:

1. You may fill out this document electronically or through a printed and physically signed form. Provide all the information requested so we can process your claim as quickly as possible.
2. The insured's death certificate and the beneficiary(ies) claim form are required to file your claim.
   - **Change of Name:** If your name has legally changed, please provide a copy of legal documentation or government-issued IDs verifying your identity. Ex. Marriage Certificate, Divorce Decree, Driver's License, etc.
3. Beneficiary requirements vary—please review the scenarios below to find the one that fits your situation:
   - **Individual:** The claim form must be completed by the individual beneficiary(ies).
   - **Trust:** The claim form must be completed by the trustee(s) and include the full name of the trust along with the trust documents or certification of trust.
   - **Estate:** The claim form must be completed by the Executor(s) or Administrator(s) and submitted with the Letters issued by the Court appointing that individual.
   - **Company or Corporation:** The claim form must be signed by two officers and include each officer's title along with a copy of the corporation resolution.
   - **Minor:** The claim form may be completed by the Court appointed Guardian of the minor's Estate and submitted with a copy of the Court issued appointment or in accordance with other applicable state law.
   - **Assignee:** If the policy has been collaterally assigned by the owner prior to the death of the insured, a statement of interest is also required. This document provides a statement of the assignee's interest and may be obtained by contacting our office.

Payment Options:
We are committed to processing your claim as quickly as possible. Please review the available payment options for approved claims.

- Lump sum check that will be mailed to you via the United States Postal Service.
- Electronic Funds Transfer (EFT):
  - Funds will be deposited directly to the verified bank account in the beneficiary's name.
  - You will need to either submit a direct deposit authorization from your bank on letterhead OR include a copy of a voided check.

Where can I obtain more information about these accounts and the services provided? If you have questions, you can contact us as follows:

- Web: www.greatsouthern.com/claims/#contact-claims

Submitting Documents:

- If you are using the electronic form, this claim form will automatically be submitted upon completion.
- If you are filling out a paper copy, please email your completed claim forms and the insured's death certificate as a PDF to forms@greatsouthern.com.
  - You may also mail your completed claim forms and the insured's death certificate to the address below.

Regular Mail:
PO BOX 410249
Kansas City, MO, 64141-0249

Overnight Mail:
300 W. 11th Street
Kansas City, MO, 64105

SECTION 1: About You (Beneficiary) ({Company Number}-{Policy Number})

If your name has changed, please attach all verifying documentation to your claim submission. Each beneficiary must complete their own claim forms, but only one death certificate is required. All beneficiaries can file their claim electronically through greatsouthern.com.

Beneficiary Name (First, Middle, Last)		
Relationship to the Insured	Maiden Name (if applicable)	Social Security Number/TIN
Mailing Address		
City	State	ZIP Code
Country of Citizenship	Date of Birth (mm/dd/yyyy)	Phone Number
Email address		

SECTION 2: About the Deceased

Deceased Name (First, Middle, Last)			
Residence Address	City	State	Zip Code
Deceased's Driver's License Number and State of Issuance	Deceased's Social Security Number/TIN		
Date of Birth (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)	Cause of Death	

Manner of Death	Marital Status
☐ Natural ☐ Accidental ☐ Homicide ☐ Suicide ☐ Undetermined	☐ Single ☐ Married ☐ Divorced ☐ Widowed

SECTION 3: About Your Claim

Please list the policy number and prefix (if applicable) for all policies on which you are making a claim.

SECTION 4: Select Your Payment Option:

- ☐ **Check** – Lump Sum
- ☐ **EFT** – Please complete and sign the bank authorization included in this package. For expedited service we recommend attaching a copy of a voided check. If not provided, we will attempt an electronic verification and if unsuccessful we will move forward with a check.
- ☐ **Alternative Settlement Options** – If you would like information of Alternative Settlement Options, we will send you additional information upon request.

- **For Illinois residents and policies issued in Illinois only: Unless payment is made within thirty-one (31) days from the date of receipt by the company of due proof of loss, interest shall accrue on the proceeds payable from the date of the insured's death at a rate of 10% on the total amount payable or the face amount if payments are to be made in installments until the total payment or first installment is paid.**

SECTION 5: Claims Submission Checklist (please check off items you are sending with this form)

Required:

☐ **Death Certificate** – Note: If your claim is more than $150,000.00, we require an original certified death certificate to be mailed in. *Additional documents may be required based on the policy.*

Please check all applicable items below:

☐ **Funeral Home or Assignment Authorization** – If you have signed a document with a funeral home or assignment company authorizing us to make payment directly to them, please provide a copy of that assignment. Check the box and enter total amount assigned here: $_____.

☐ **Accidental Death Benefit Claim** – If you are making an accidental death benefit claim, please provide any police, coroner, or autopsy reports, and/or other supporting documentation.

☐ **Power of Attorney** – If you have Power of Attorney, provide a copy of the appointment papers naming you as the attorney-in-fact for the beneficiary.

If you have additional comments, please note them here:

SECTION 6: Certification and Signature

By signing this claim form, you certify that:

- All the information you have provided is true and complete to the best of your knowledge.
- If we overpay you, we have the right to recover the amount we overpaid. This can happen if we find we've paid you more than you're entitled to under this life insurance claim, or if we paid you when we should have paid someone else. You agree to repay us the amount we overpaid or misapplied. You also understand that if you do not repay us, we may take steps, including legal action, to recover the overpayment.
- You have read the Claim Fraud Warnings included with this form.

Under Penalties of Perjury, I Certify:

1. That the number shown as my Social Security number in "Section 1: About you" above is my correct taxpayer identification number, and
2. That I am not subject to backup withholding because:
    a. I am exempt from backup withholding, or
    b. I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or
    c. The IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen, resident alien, or other U.S. person*, and
4. I am not subject to FATCA reporting because I am a U.S. person* and the account is located within the United States.

(Please note: You must cross out Item 2 above if the IRS has notified you that you are currently subject to backup withholding because you failed to report all interest or dividend income on your tax return.)

*If you are not a U.S. Citizen, a U.S. resident alien, or other U.S. person for tax purposes, please cross out Items 3 and 4 above, and complete and submit form W-8BEN (individuals) or W-8BEN-E (entities).

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

Signature of Person/Representative Making Claim	Date signed (mm/dd/yyyy)

If acting as a representative, please sign with your title and provide supporting documentation.

Fraud Notice

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Before signing any claim form, please read the applicable fraud warning for the state where you reside and for the state where the insurance policy under which you are claiming benefits was issued. Many States require the Insurer to provide claimants with a Fraud Statement, such as the following:

WARNING: 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.

The following States require the insurer to provide claimants with the specific language below:
Maine, Tennessee, Washington, Virginia: 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.

Delaware, Idaho, Indiana: WARNING: 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.

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.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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 purposes 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.

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.

Minnesota: A person who files a claim with the 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 NH R.S.A Section 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 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 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.

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.

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 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 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 be 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.

Authorization and
Consent to Disclosure

GSL-CLM-00043 (01/26)

GREAT SOUTHERN
LIFE INSURANCE COMPANY

This form is HIPAA compliant

Policy Number:_____

Decedent: _____

Purpose of Authorization: Process Insurance Claim

I/We, individually and/or as authorized representative for the decedent ("Decedent's Representative"), authorize any insurance or reinsurance company, employer, Social Security Administration, licensed medical physician, medical professional, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, clearing house, consumer reporting agency, and/or the Medical Information Bureau ("MIB, Inc.") or any other person, organization or institution that has any record of information about the decedent or minor children who are/were insured, to give Great Southern Life Insurance Company ("Great Southern"), its reinsurers or its authorized representatives, information about other insurance coverage, employment, age, general character, motor vehicle records, habits, court records, foreign travel, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including medications prescribed, chart notes, labs, x-rays and special tests, information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, and the use of drugs, alcohol, tobacco and psychotherapy notes and alcoholism, required by Great Southern to determine insurability and/or claims eligibility for the duration of the claim.

Great Southern may release information obtained by this Authorization to its reinsurers, to MIB, Inc., to other insurers with whom the decedent has/had policies or to whom the Decedent's Representative may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for the decedent, or as may otherwise be lawfully required. Although federal regulations require that Great Southern inform You (the Decedent's Representative) of the potential that information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Great Southern pursuant to this Authorization will be protected by federal and state privacy laws and regulations.

The Decedent's Representative may obtain a copy of this Authorization on request. This Authorization will be valid for two (2) years from the date signed. It is Great Southern's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. The Decedent's Representative understands that a copy of this Authorization will be provided, upon request, to the Decedent's Representative or a person authorized on the decedent's behalf.

This Authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Great Southern has taken action in reliance on this Authorization. Notice of revocation may be sent, in writing, to Great Southern at its Administrative Office address.

_____ _____
Signature of Next of kin or Executor (rix) of Estate | Date

_____ _____
Relationship | Initial here if Estate of Insured has not and will not be probated

_____ _____
Signature of Informant on Death Certificate | Date

NOT TO BE COMPLETED BY THE BENEFICIARY. TO BE COMPLETED BY THE COMPANY.

Name of Decedent: _____ DOB: _____ SSN: _____

Records Provider: _____ Type of records to be released: _____

Time period of requested records: _____ to _____

Affidavit of Next of Kin

GSL-CLM-00041 (01/26)

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To be completed by next of kin who does **NOT** have legal appointment as Personal Representative/Administrator for deceased patient and there will be **no Probate** filing.

The undersigned, being first duly sworn, deposes and says:

1. That I am the next of kin of, _____, who died on or about the ___day of _____, 20___.
2. That _____is handling the affairs of deceased _____ and stands next in line of intestate succession.
3. That this affidavit is made in support of the undersigned's request for the release of the decedent's medical records.

Dated the ___day of _____, 20___.

_____ _____

Signature Relationship

SUBSCRIBED AND SWORN to before me this ___day of _____, 20___, by _____.

_____ Notary Seal

Notary Public

My Commission Expires: _____

Health
Statement

GSL-CLM-00042 (01/26)

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- *Please complete this form for the time period of 3-5 years prior to the date of the Decedent's passing.*
- *If you need more space to provide the medical provider information, please put that on a separate sheet of paper.*
- ***NOTE: NOT to be completed by a physician/medical professional. Great Southern will obtain the records.***

Name of Decedent	Policy Number

Complete the information below for each of the Decedent's medical providers. If additional space is needed, please use a separate sheet of paper.

Name of Doctor or Provider	Please select one: ☐ Primary/Family Doctor ☐ Specialist ☐ Clinic/Other
Address of Doctor or Provider	Telephone Number of Doctor or Provider
Date Range of Service (month/year)	Type of Specialty

Name of Doctor or Provider	Please select one: ☐ Primary/Family Doctor ☐ Specialist ☐ Clinic/Other
Address of Doctor or Provider	Telephone Number of Doctor or Provider
Date Range of Service (month/year)	Type of Specialty

Name of Doctor or Provider	Please select one: ☐ Primary/Family Doctor ☐ Specialist ☐ Clinic/Other
Address of Doctor or Provider	Telephone Number of Doctor or Provider
Date Range of Service (month/year)	Type of Specialty

Had the Decedent been hospitalized within the time period of 5 years prior to the date of the Decedent's passing? .... ☐ Yes ☐ No
If **Yes**, please complete the next section.

Name of Hospital(s)	Telephone Number of Hospital(s)
Address of Hospital(s)	
Dates of Service(s)	Reason for Visit(s)

Was the Decedent prescribed or did he or she use any prescription drugs prior to death for any of the following conditions? .... ☐ Yes ☐ No

Diabetes	☐ Yes ☐ No	COPD/Emphysema/Lung Disease	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Kidney Disease/Liver Disease	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Alcohol or Drug Treatment	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Other: ____________________	☐ Yes ☐ No
Alzheimer's Disease/Dementia	☐ Yes ☐ No		

Name of Pharmacy(ies) used to fill prescriptions	Telephone Number of Pharmacy(ies)
Address of Pharmacy(ies)	

Did the Decedent smoke cigarettes or use other nicotine products within a time period of 5 years prior to the date of the Decedent's passing? .... ☐ Yes ☐ No
If **Yes**, what nicotine product was used and how frequently was it used? ____________________
Cause of Decedent's death? ____________________
Date underlying condition causing death was first treated: ____________________

I declare that the facts stated on this form are complete and true to the best of my knowledge and belief. **Warning:** A person who files a claim containing false, incomplete or misleading information, may be guilty of a felony or misdemeanor.

______________________ Signature

______________________ Relationship to Decedent

______________________ Date