



## **Bankers Fidelity Life Insurance Company®**

4370 Peachtree Road NE, Atlanta, Georgia 30319

Phone: (866) 458-7499

Losing a loved one is one of the most difficult life events we ever have to face. Fortunately, your loved one established a life insurance policy to help provide you and your family the support you need during this stressful time.

This guide provides information and instruction to help successfully complete and submit your claim.

### **What documents do I need to submit?**

- Claim Form—Signed by the beneficiary/beneficiaries
- Certified Death Certificate
- Copy of obituary (if available)
- Physician and Authorization forms—Only required if death occurred within the first two (2) years of the policy issue date
- Police Report (if applicable)—Only required if the death was the result of an accident, suicide or homicide

### **What documents do I need to submit if the named beneficiary is deceased?**

- Copy of the death certificate of named beneficiary; or
- Copy of obituary of the named beneficiary

### **What documents do I need to submit if beneficiary is a minor (under age 18)?**

- Copy of Birth Certificate
- Probate Court Guardianship documents

### **What documents do I need to submit if the life proceeds are assigned to a funeral home?**

- Assignment form provided by the funeral home

### **What documents do I need to submit if the claim is being paid to an estate or a trust?**

- Letters of testamentary
- Letters of administration
- Other qualifying legal documents issued by the probate court
- Copy of the trust documents (if applicable)

## **Submitting Your Claim**

**Email:** [claims@bflic.com](mailto:claims@bflic.com)

**Mail:** Bankers Fidelity Life Insurance Company  
Attn: Claims Department  
4370 Peachtree Road NE  
Atlanta, Georgia 30319

## **Claims Questions**

Phone: (866) 458-7499

Email: [Ancillaryclaims@bflic.com](mailto:Ancillaryclaims@bflic.com)



## NOTICE

WARNING: 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 may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

### **Alabama Residents Only**

WARNING: 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.

### **Arkansas Residents Only**

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.

### **District of Columbia Residents Only**

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 Residents Only**

WARNING: 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.

### **Louisiana Residents Only**

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.

### **Maryland Residents Only**

WARNING: 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 may be guilty of insurance fraud as determined by a court of competent jurisdiction.

### **Pennsylvania Residents Only**

WARNING: 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.

### **Tennessee Residents Only**

WARNING: 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.

### **Virginia Residents Only**

WARNING: 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 state law.

### **Washington Residents Only**

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.





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**Medical Information Request Form**

<b>INSURED NAME</b>		<b>POLICY/CERTIFICATE NUMBER</b>	
(First, Middle & Last)			
Please provide the names, complete addresses and telephone numbers of all physicians, hospitals and pharmacies who have treated or dispensed medication to the insured within the last 5 years in the area below.			
<b>1. PRIMARY CARE PHYSICIAN</b>		Telephone Number	
Street Address		Date First Seen Mo. _____ Yr. _____	
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____	
<b>2. PHARMACY NAME</b>		Telephone Number	
Street Address			
(City, State & Zip Code)			
<b>3. HOSPITAL/CLINIC</b>		Telephone Number	
Street Address		Date First Seen Mo. _____ Yr. _____	
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____	
<b>4. NURSING HOME</b>		Telephone Number	
Street Address		Date First Seen Mo. _____ Yr. _____	
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____	
<b>5. OTHER PROVIDER</b>		Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____	
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____	

<b>1. OTHER PROVIDER</b>	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
<b>2. OTHER PROVIDER</b>	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
<b>3. OTHER PROVIDER</b>	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
<b>4. OTHER PROVIDER</b>	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
<b>5. OTHER PROVIDER</b>	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____

\*If additional space is required please use a separate sheet of paper. The more complete the information the quicker we will be able to conclude our review.