BANKERS CONSECO LIFE INSURANCE COMPANY

ACCIDENTAL DEATH CLAIM FORM

TOLL-FREE PHONE: 1-800-851-2618

INSTRUCTIONS

1. Please complete the Claimant's Statement and sign and date the Authorization.
2. Have the deceased's attending physician complete the Physician's Statement on the other side of this form.
3. Mail the completed claim form to: **Bankers Conseco Life Insurance Company**
   Administrative Office - Life Claims Depart.
   399 Market Street
   Philadelphia, PA 19106

Notice: 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. See page 3 for important information regarding fraud that may apply in your state.

CLAIMANT'S STATEMENT

PLEASE PRINT OR TYPE

Deceased's Name _____ Social Security # _ _ _ _ _ _ _ _ _

Policy #(s) _____

Residence at death _____
Street City State Zip Code

Date of Birth _____ Place of Birth _____

Beneficiary's Name _____ Age _____ Beneficiary's Telephone # _____
Area Code Number

Beneficiary's Mailing Address _____
Street Apt. City State Zip Code

Date of the accident _____ Where did it occur? _____

What happened?* _____

_____ Date of Death _____

* Note: Please submit any newspaper accounts of the accident **AND** a copy of the Police Report if one was filed.

Please describe the injury resulting from the accident _____

Is insured entitled to benefits under any worker's compensation act or similar law for this injury? Yes ( ) No ( )

Name and address of attending physician: _____

_____

Name and address of family physician: _____

_____

Name and addresses of all other physicians or practitioners who attended the deceased during the last five years:

Name and address	Dates(s) of treatment

Names and addresses of all hospitals or institutions where deceased was treated during the last five years:

_____

_____

AUTHORIZATION

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I permit (while this claim is pending) the release of any medical information about the deceased to Bankers Conseco Life Insurance Company and its representatives. Bankers Conseco Life Insurance Company's representatives include reinsuring companies and other persons or groups performing business or legal services relating to this claim. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury the deceased had prior to or at the time of death. Bankers Conseco Life Insurance Company will use this information to find out if this claim is eligible. A copy of this authorization (one of which will be given to me by Bankers Conseco Life Insurance Company upon my request) will be as valid as this one. This authorization will be valid for a period of 24 months from the date signed.

Deceased's Name _____ **Date** _____

Beneficiary's Signature _____ **Beneficiary's Social Security #** _ _ _ _ _ _ _ _ _

Relationship to Deceased _____

PHYSICIAN'S STATMENT ON OTHER SIDE.

PHYSICIAN'S STATEMENT

PLEASE PRINT OR TYPE

Full name of Deceased _____ Age _____ Sex F ( ) M ( )

Date of death _____ Place of death _____
Month Day Year

Immediate or proximate cause of death _____

Underlying cause(s) of death _____

_____

Other significant conditions _____

Mode of death (Specify One) ( ) Natural ( ) Accident ( ) Suicide ( ) Homicide

If accident, date of injury _____ Place of injury _____
Month Day Year

Injury occurred: ( ) At work ( ) Not while at work How did injury occur? _____

_____

When did you first attend the deceased for the fatal accident/illness? _____

When did you last attend the deceased for the fatal accident/illness? _____

Was an official inquiry held? Yes ( ) No ( ) If yes, state results _____

_____

Was an autopsy performed? Yes ( ) No ( ) If yes, state cause of death and attach a copy of the autopsy report.

_____

Please list all conditions for which you treated or advised the deceased during the last five years.

Condition	Date(s) of service/treatment

Please give names and addresses of any other physicians or practitioners who attended the deceased and all hospitals or institutions where deceased was treated or advised during the last five years.

Name and address	Date(s)	Condition(s)

The answers I have made to the above questions are true and complete to the best of my knowledge and belief.

Physician's Name (Please Print) _____

Physician's Signature _____

Address _____
Street City State Zip Code

Degree _____ Telephone # _____ Date _____
Area Code Number

SPECIAL STATE CLAIM FRAUD WARNINGS

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.

ARKANSAS, NEW MEXICO & RHODE ISLAND

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.

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

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 or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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.

LOUISIANA, MAINE, TENNESSEE & VIRGINIA & 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 may include imprisonment, fines or a denial of insurance benefits.

MARYLAND

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.

MINNESOTA, OHIO & OKLAHOMA

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 is guilty of insurance fraud.

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 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.

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.