



Group Life Department
1350 Main Street
Springfield, MA 01103-1650

BC Life & Health Insurance Company would like to extend our condolences on your recent loss. We want to assure you that we will do our best to process your claim in a timely manner.

Lump sum proceeds of \$5,000 and more are paid through our Control Plus AccountSM program. Control Plus Account is a checkbook program paying competitive money market interest rates on the balances in your account and it is fully guaranteed by BC Life & Health Insurance Company. This improved method of payment is provided without cost to you.

As soon as your claim is approved, we will send your Control Plus Account kit containing your checkbook. Your funds will be immediately available to you simply by writing a check. You will have the opportunity to withdraw money as you need it, leaving the balance earning money market interest rates, or you may withdraw the total amount - it's all based upon your needs.

If you have questions, we encourage you to call our Beneficiary Service Center at our toll-free number, 1-800-551-7564, Monday through Friday, 8:30 a.m. to 4:30 p.m. eastern time. Inquiries originating outside the U.S. can call us collect at 413-858-5402, during the same hours listed above. We are pleased to be able to serve you and hope we have relieved you of one worry during this difficult time.

Respectfully,

BC Life & Health Insurance Company



How to Complete Your Beneficiary Claim Form

Please read this page before you complete the Beneficiary Claim Form.

BC Life begins gathering information for your claim as soon as it learns of the death.* To complete processing of your claim, we must have:

1. A fully completed Beneficiary Claim Form from each beneficiary. (You may use a photo copy of the attached form if there is more than one beneficiary.)
2. A certified copy of the death certificate.
3. A copy of the enrollment form or beneficiary designation form on which the insured named beneficiaries.

SECTION 1: Claimant/Beneficiary Information

This information enables us to speed payment to you. Your telephone number(s) help us contact you quickly if any required information has been omitted.

Social Security Number

In nearly all cases, life insurance benefits are NOT subject to income tax. However, because you will be earning taxable interest under the Control Plus Account program, the Federal government requires us, and all other financial institutions that pay interest, to ask for and obtain your Social Security Number or other Taxpayer Identification Number. If you fail to supply us with your Social Security Number or other Taxpayer Identification Number, the Federal government requires us to withhold a portion of any interest we would otherwise pay you as a deposit against the taxes that may be due. If you are applying for a tax number, please write "applied for" in the appropriate space.

Some persons have been notified by the Internal Revenue Service that they are subject to "backup withholding" because in the past they did not report all their interest or dividends. If you have been so notified, and the Internal Revenue Service has not written to you stating that you are no longer subject to backup withholding, you must cross out the statement right below your Social Security Number or Taxpayer Identification Number.

We may need to contact you for more information if you are not a citizen of the United States and/or you reside in a foreign country.

Claims by an Estate or Assignee

If this claim is being filed by an Executor or Administrator, he or she must sign the Beneficiary Claim Form and submit certified copies of the appointment papers. Be sure to use the estate's taxpayer number.

Assignment of Benefits

If you have assigned all or any portion of the claim to a funeral home for final expenses, please include a copy of that assignment and the itemized bill.

If the policy proceeds have been assigned to a bank or other financial institution, the Beneficiary Claim Form must be signed by an authorized representative of that institution.

SECTION 2: Information About the Insured (the Deceased)

This information is necessary for purposes of identification. If the insurance coverage was issued within two years of the insured's death, or the death was due to an accident and the Group Policy provided for accidental death benefits, we may ask you for additional information.

SECTION 3: Signature and Certification

Sign the Beneficiary Claim Form in the same manner as you would sign checks. Your signature may be used to verify Control Plus Account checks you write or instructions you give us in the future. You will also be certifying, under penalties of perjury, that your Social Security Number or other Taxpayer Identification Number and backup withholding status are true.

* This Claim Form may have been sent before BC Life has determined whether any insurance was in force at the time of death, whether any proceeds are payable, and to whom any proceeds are payable. BC Life retains its rights to make these determinations.



Beneficiary Claim Form

FOR GROUP POLICYHOLDER USE ONLY.

Please return this Beneficiary Claim Form together with an official certified copy of the Death Certificate to the Insured's group employer.

Group No.	Employer
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SECTION 1. Claimant/Beneficiary Information – Please type or print legibly. Name and address as stated will appear on checks.

Name of Claimant/Beneficiary – First name, Middle initial, Last name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address	Apartment No.	Home Phone No. ()
City / State / ZIP code		Daytime Phone No. ()
Social Security Number or Taxpayer Identification No.		Date of Birth

I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or I am exempt. **Cross out this statement if you have been so notified.**

In what capacity are you making this claim? Beneficiary Executor Trustee Other: _____

Claimant's relationship to the Insured: Spouse Child Parent Other: _____

SECTION 2. Information about the Insured (the Deceased)

Name of Insured (the Deceased) – First name, Middle initial, Last name
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SECTION 3. Signature and Certification

I certify, under penalty of perjury, that the Social Security Number or other Taxpayer Identification Number and Claimants Backup Withholding status information in Section 1 is correct. I understand that my signature may be used for signature verification for my Control Plus Account and other purposes.

Signature (Sign as you would a check. Signature may be used for check verification.) X	Date
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It is a crime to knowingly, with intent to defraud, file a statement of claim containing any materially false or misleading information, or to conceal any material fact. Untrue or misleading statements may subject persons to criminal prosecution and civil penalties.

SEND THIS COMPLETED FORM TO:

BC Life & Health Insurance Company
Life Claims Unit
P.O. Box 1210
Springfield, MA 01101-1210
1-800-551-7564

For Use by BC Life only

Examiner	Claim No.	Date Approved/Denied	Branch	Total – Benefit and Interest
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Detach here and return to the Insured's Group Employer.



Group Policyholder's Statement

FOR USE BY GROUP POLICYHOLDER ONLY. NOT FOR USE BY BENEFICIARY(S).

Please print all items. Any omissions may cause a delay in claim processing.

Policy and Employer Data

Group No.	PCC	Claim Branch	Optional, additional, or supplemental (if different than basic)	PCC	Claim Branch	or	Case	Group	Suffix
To whom do you wish us to direct all correspondence on this claim?		Company				To the Attention of: _____ Title _____			
		Phone No. ()		Address / City / State / ZIP code					

Employee Data

Full name of Insured Employee				Social Security No.		Date of Birth		Date Employed	
LAST CHANGE IN AMOUNT OF INSURANCE					Rate of Pay		Original date of individual's insurance with BC Life		
Type of Insurance	Amount of Insurance	Increase	Decrease	Date	\$ per		Job Title (per life insurance schedule)		
Basic Life	\$	\$	\$				Date Last Worked _____ Date of Death _____		
Opt./Add'l/Supp. Life	\$	\$	\$				Has insurance been terminated prior to death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
AD&D	\$	\$	\$				If yes, Indicate date: _____		
Supp. AD&D	\$	\$	\$						
TOTAL	\$	\$	\$						
Was deceased insured for Group Survivor Income Benefits?					<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, complete form 10GB SIB.		
Was claim for Waiver of Premium or Permanent & Total Disability Benefits submitted prior to death?					<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, claim no: _____		
Reason for Ceasing Work					Was insured considered member/employee at the time of death?				
<input type="checkbox"/> Illness (including disability leave of absence) <input type="checkbox"/> Leave of Absence (other than disability)					<input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Quit <input type="checkbox"/> Dismissed <input type="checkbox"/> Vacation <input type="checkbox"/> Temporary layoff <input type="checkbox"/> Retired									

Dependent Data

Full name of Dependent			Social Security No.		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	
Street Address					City / State / ZIP code			
Relationship to insured employee <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child <input type="checkbox"/> Other:					If spouse, was he/she divorced or legally separated? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If child, was he/she: Married: <input type="checkbox"/> Yes <input type="checkbox"/> No Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No Full-time student: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was employment: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time Date employed: _____								
Date Dependent Insured under BC Life		Was insurance terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate date: _____			Amount of Dependent's insurance claimed \$		Date of Dependent's death	

Accidental Death Claim Information

If the Group Program provided an Accidental Death benefit and the death was due to an accident, please complete this section and attach copies of descriptive news articles and a police or coroner's report, if available.

Date of Accident	Was the death due to injury arising out of and during the course of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Beneficiary Data – If a Beneficiary who is entitled to a benefit is deceased, give name, date of death, and furnish a copy of his or her Death Certificate.

Name of Each Beneficiary	Social Security No. or Tax I.D. No if Estate or Trusts	Relationship to Employee	Age	Address (Street address / City / State / ZIP code)

Signature – The information given above is correct and complete according to our records.

Employer (if other than policyholder) Affiliate, Subsidiary, Branch, Employer number	By (Signature & Title of Employer's Authorized Representative) X	Date
Policyholder	By (Signature & Title of Employer's Authorized Representative) X	Date