Life Claims Service Center
P.O. Box 105488
Atlanta, GA 30348-5448

Please accept our condolences on your recent loss. We realize there is not much we can say that will comfort you during this difficult time. However, we will do our best to assure that all your dealings with us are handled in a professional, caring and timely manner.

To better meet your needs and speed the processing of your claim, lump sum proceeds of $5,000 and more are paid though our Control Plus Account$_{SM}$ 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 Greater Georgia Life (GGL). This improved method of payment is provided without cost to you as an additional benefit under a Group policy.

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, 1-800-552-2137, Monday to Friday, 8:30 a.m. to 4:30 p.m. eastern time. We are pleased to be able to serve you and hope we have relieved you of one worry during this difficult time.

Respectfully yours,

Greater Georgia Life

How to Complete Your Beneficiary Claim Form

Please read this page before you fill out the Beneficiary Claim Form.

Greater Georgia 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 is 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

Please 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 GGL 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. GGL retains its rights to make these determinations.

FOR GROUP POLICYHOLDER USE ONLY

Group Number _____ **Employer** _____

Beneficiary Claim Form

PLEASE RETURN THIS BENEFICIARY CLAIM FORM TOGETHER WITH AN OFFICIAL CERTIFIED COPY OF THE DEATH CERTIFICATE TO THE INSURED'S GROUP EMPLOYER.

Section 1: Claimant/Beneficiary Information

Please type or print legibly. Name and address as stated will appear on checks.

Name _____ Sex: ○ Male ○ Female
First *Middle Initial* *Last*

Address _____ Home Phone ( )
Street *Apartment No.*

_____ Daytime Phone ( )
City *State* *Zip*

Beneficiary's Social Security Number or
Taxpayer Identification _____ Date of Birth _____
Month Day Year

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 _____
First *Middle Initial* *Last*

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 _____ *Date* _____
(Sign as you would a check. Signature may be used for check verification.)

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.

For Use By GGL Only

Examiner	*Claim #*	*Date Approved/ Denied*	*Benefit*	*Total (Benefit and Interest)*

Return to:

Life Claims Service Center
PO Box 105448
Atlanta, GA 30348-5448

FOR USE BY THE GROUP POLICYHOLDER. NOT FOR USE BY BENEFICIARIES.

Group Policyholder's Statement

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

Policy and Employer Data

Group Number	PCC	Claim Br.	Optional, additional, or supplemental (If different than basic)	PCC	Claim Br.	or	Case	Group	Suffix

TO WHOM DO YOU WISH US TO DIRECT ALL CORRESPONDENCE ON THIS CLAIM?	Company	To the attention of	Title
	Telephone No.	Address (No. & Street)	(City) (State) (Zip Code)

Employee Data

Full Name of Insured Employee	Social Security Number	Date of Birth	Date Employed

Last Change in Amount of Insurance

Type of Insurance	Amount of Insurance	Increase	Decrease	Date
Basic Life	$	$	$	
Opt./Add'l/ Supp. Life	$	$	$	
AD & D	$	$	$	
Supp. AD & D	$	$	$	
TOTAL	$	$	$	

Rate of Pay
$ per _____

Original date of individual's insurance with GGL

Job Title (per life insurance schedule)

Date Last Worked

Date of Death

Had insurance been terminated prior to death? ○ Yes ○ No

If yes, indicate date

Was deceased insured for Group Survivor Income Benefits? ○ Yes ○ No If yes, complete form 10G SIB.

Was claim for Waiver of Premium or Permanent & Total Disability Benefits submitted prior to death? ○ Yes ○ No If yes, claim #: _____

Reason for Ceasing Work

○ Illness (including disability leave of absence) ○ Leave of Absence (other than disability)
○ Quit ○ Dismissed ○ Vacation ○ Temporary Layoff ○ Retired

Was insured considered member/employee at the time of death? ○ Yes ○ No

Dependent Data

Complete this section if this claim is for an insured dependent

Full name of Dependent	Social Security Number	○ Male ○ Female	Date of Birth

Address (No. & Street)	City	State	Zip Code

Relationship to insured employee
○ Wife
○ Husband
○ Child

If spouse, was he/she divorced or legally separated? ○ Yes ○ No

If child, was he/she:
Married? ○ Yes ○ No
Employed? ○ Yes ○ No
Full time student? ○ Yes ○ No
If yes, was employment ○ Full-time ○ Part-time
Date Employed:

Date Dependent insured under GGL Insurance	Was Insurance terminated? ○ Yes ○ No If yes, indicate date:	Amount of Dependent's Insurance claimed $	Date of Dependent's death

Accidental Death Claim Information

Date of Accident or Incident	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.
	Was the death due to injury arising out of and during the course of employment? ○ Yes ○ No

Beneficiary Data

Name of each Beneficiary	Social Security No. or Tax I.D. No. if Estate or Trusts	Relationship to Employee	Age	Address (No. + Street, City, State, Zip Code)

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.

THE INFORMATION GIVEN ABOVE IS CORRECT & COMPLETE ACCORDING TO OUR RECORDS.

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