

Claim Form – Life Insurance Plan

IMPORTANT: "Statement of Claimant" must be completed in all cases. If there are two or more beneficiaries or other claimants, each beneficiary must complete a "Statement of Claimant". Each beneficiary must make a separate statement.

Statement of Claimant

POLICY NUMBER(S): _____

1 Decedent Information – (Please print in ink or type)

Name	First	Middle	Last		
Residence at time of death	Street	City	State	Zip	
Date of Birth	Place of Death				
Date of Death	Cause of Death		Manner of Death		

2 Beneficiary or Claimant Information

Name	First	Middle	Last	Social Security Number/Tax ID Number	
Residence	Street	City	State	Zip	
Date of Birth	Day Time Telephone		Relationship to Deceased		

Are you subject to back-up withholding? (Has the IRS contacted you directly to inform you that you are subject to back-up withholding?)
 Yes No

In what capacity or title do you Claim this Insurance? Check one:

- Beneficiary Assignee Trustee Executor / Administrator Guardian
- Other

3 Statement of Lost Policy (Complete only if policy is unavailable for return)

I am unable to locate the original life insurance policy. I agree to return the policy to the company if found.

4 **Payment of Fund – Please Select One**

Single Sum Payment (Check)

Installment Payments *(Please refer to the policy for options. If policy is not available, please contact our office.)*

Installment Option Elected _____

Payment Frequency: Monthly Quarterly Semi-Annually Annually

5 **Signatures**

The undersigned hereby makes claim to said insurance (or contractual portion thereof, if more than one claimant) and agrees that the furnishing of this form or any of the forms supplemental thereto by the Company shall not constitute nor be considered an admission by it that there was any insurance in force on the life in question nor a waiver of any of its rights or defenses.

Any person who knowingly and with intent to defraud any insurance company or any 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.

Information Authorization

Any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge about the insured is hereby authorized to disclose any such information. A photographic copy of this authorization shall be as valid as the original. (This information will only be obtained for contestable claims.)

“Under the penalties of perjury, I certify that the information supplied on this form is true, correct and complete.”

Claimant Signature Date

Please Print Name

Notary

State of _____
County of _____ } **SS.**

Date: _____ personally appeared before me at _____

State of _____ the above Claimant, who is known to me and who subscribed the foregoing statement before me and stated under oath that the statements and answers above made and subscribed are true and full.

In Witness Whereof, I have hereunto subscribed my name and affixed my official seal.

(Seal)
My Commission Expires: _____

Notary Public