Fidelity Life Association, A Legal Reserve Life Insurance Company / "The Company" Administrative Office: 1350 E Touhy Ave., Suite 205W
Des Plaines, IL 60018
Phone Number: (800) 369-3990

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.

(See Other Side)

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.

Fraud Statement: 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.

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