

**Please Print Clearly**

**CLAIMANT'S STATEMENT**

Date: \_\_\_\_\_

To the above Insurance Company: I hereby make claim under the policy/certificate or policies/certificates of the Company, numbered as follows: {Policy Number} \_\_\_\_\_ Claim # {Claim Number} \_\_\_\_\_

1. a. Name of deceased in full: \_\_\_\_\_  
b. Last known address of deceased: \_\_\_\_\_  
c. Occupation at death: \_\_\_\_\_
2. a. Date of death: \_\_\_\_\_ b. Place of death: \_\_\_\_\_  
c. Cause of death: \_\_\_\_\_ d. If death was due to suicide, homicide, or accident, state which and describe briefly: \_\_\_\_\_
3. Name and address of attending mortician: \_\_\_\_\_
4. On what date did deceased first complain of or give other indications of last illness? \_\_\_\_\_
5. a. BIRTH date of deceased: \_\_\_\_\_ State of Birth: \_\_\_\_\_  
b. From what source was the above date of birth obtained (from family record, certificate of birth, or otherwise)? \_\_\_\_\_
6. a. What is the beneficiary's date of birth? \_\_\_\_\_  
b. What is the beneficiary's Social Security /Trust Identification/Estate Identification No.? \_\_\_\_\_  
c. What is the beneficiary's phone number? \_\_\_\_\_  
d. What is the beneficiary's relationship to the deceased? \_\_\_\_\_  
e. State the amount of the claim: \_\_\_\_\_

Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

I certify, under penalty of perjury, that the Social Security or Taxpayer Identification Number and Back-up Withholding status information are correct. I further certify that I am a U.S. person, including a U.S. resident alien (non-U.S. person must complete for W-8BEN).

All of the above answers and statements are true and complete, and correctly recorded. I understand that the furnishing of forms by the Company does not constitute an admission that there is any insurance coverage in force or payable.

The policy/certificate IS / IS NOT (circle one) attached. (See Instructions (5) on back)

\_\_\_\_\_  
Personal Signature of Witness  
\_\_\_\_\_  
Printed Name of Witness  
\_\_\_\_\_  
Address of Witness  
\_\_\_\_\_  
City, State, ZIP of Witness

\_\_\_\_\_  
Personal Signature of Claimant  
\_\_\_\_\_  
Printed Name of Claimant  
\_\_\_\_\_  
Address of Claimant  
\_\_\_\_\_  
City, State, ZIP of Claimant

## NOTE

If you have questions after reviewing the following instructions, please contact your local representative or the claims department at the number listed in the attached letter.

It is unnecessary for a claimant to incur any expense by employing the services of a third person to make claim under the policy.

The furnishing of this form shall not be held to be a waiver or any breach of any conditions of the policy which is the basis of the claim made hereunder.

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## INSTRUCTIONS

### **Please read the following instructions carefully and comply with them fully**

- (1) To make claim under a policy/certificate, a Claimant's Statement must be fully completed and returned to the Company. Regardless of the number of policies/certificates involved, only one Claimant's Statement is required from each claimant. If there is more than one claimant, each claimant must execute a separate Claimant's Statement.
- (2) In executing a Claimant's Statement, a beneficiary must sign his/her name exactly as it is listed in the policy/certificate, unless the name has been changed, by marriage or otherwise. In this event, documents establishing the marriage or name change must be sent to the Company with the Claimant's Statement.
- (3) The beneficiary must also send the Company a certified copy of the death certificate. Only one death certificate is required regardless of the number of policies/certificates or claimants involved. If it is difficult to obtain a certified death certificate, a physician's statement, completed and executed by the physician who attended the insured in the last illness, may be submitted for consideration as the proof of death. Any expense incurred in obtaining either the death certificate or the physician's statement is to be paid by the beneficiary.
- (4) When available, an obituary or newspaper account of the death should be furnished.
- (5) The policy/certificate should be surrendered to the Company and should accompany the Claimant's Statement, unless previously forwarded. If the policy is lost, circle "is not attached" on the Claimant's Statement.
- (6) If the beneficiary is an estate, a Claimant's Statement must be completed by the administrator or executor of the estate, and a certified copy of the appointment of the administrator or executor by the proper court must be attached to the Claimant's Statement.
- (7) If a beneficiary is a joint beneficiary, or a contingent beneficiary, and the beneficiary's interest in the sum payable under a policy arises or is increased through the prior death of another beneficiary or settlement agreement, satisfactory proof of the beneficiary's death must be sent to the Company before the claim can be settled. A certified copy of the death certificate for each deceased beneficiary should be attached to the Claimant's Statement.
- (8) If the beneficiary is a minor, advice should be obtained from the Company prior to filing the claim. If a guardian/conservator has been or will be appointed for the estate of such minor, certified letters of guardianship/conservatorship for the minor's estate should be attached to the Claimant's Statement.
- (9) If a group of children are designated as the beneficiary of the policy, an affidavit of a surviving parent, which gives the full names, ages, and addresses of all children surviving the deceased, needs to be provided to the Company. Please contact the Company to obtain this affidavit.

**Fraud Warning:** The following state(s) and U.S. territories require that insurance claims acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state or U.S. territory as indicated below.

ALASKA: A person who knowingly and with intent to injure, defraud or deceive an insurance company files claim containing false, incomplete or misleading information may be prosecuted under state law.

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.

CALIFORNIA: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in 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 proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

DELAWARE, IDAHO, and INDIANA: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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 in the third degree.

HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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, ARKANSAS, WEST VIRGINIA AND TEXAS: Any person who knowingly presents 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.

MAINE: 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison." Note: "Claim form" means any document supplied by an insurer to a claimant that a claimant is required to complete and submit in support of a claim for benefits.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an Insurer is guilty of a crime.

NAIC: WARNING: 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.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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 MEXICO: 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 criminal 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.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OHIO: 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.

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.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TENNESEE: 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.

VIRGINIA: Any person who, with the 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 may have violated state law.

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.

**\*If the policy was issued or reinstated within TWO YEARS of the date of death, please provide the names and addresses of all physicians/hospitals who attended the deceased during the last ten years. (In the event we require this form outside this 2 year period, we will notify you in writing.)**

## MEDICAL HISTORY

Claimant Name:

Policy Number:

Please provide all previous names that the following information may be located under.

To assist us in making medical inquiries, please submit the following data in reference to all medical care during the last 10 years.

I have consulted with the following doctors:

Full Name	Full Mailing Address	Dates Consulted	Phone #
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			

I have been treated at the following hospitals, clinics, nursing homes, hospices:

Hospital Name	Full Address	Dates Confined/Treated
1. _____		
2. _____		
3. _____		

The following Prescriptions have been filled (see label on RX Bottle)

RX #	Name/Address of Pharmacy	Doctor	Drug Name
1. _____			
2. _____			
3. _____			

IF ADDITIONAL SPACE IS NEEDED PLEASE USE THE OTHER SIDE OF THIS FORM.

\_\_\_\_\_  
Claimant's Signature

\_\_\_\_\_  
Date