PROOF OF DEATH - BENEFICIARY'S STATEMENT

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

- **Service related items can be obtained directly from the patient's healthcare provider(s) by requesting a UB04 hospital bill or HCFA 1500 non-hospital bill.**
- **Failure to complete all sections may result in a delay in processing this claim.**
- **Disclaimer: Some of the services listed may not be covered by your policy/certificate.**

***Policy/Certificate Number:**

***Policyholder's/Certificate Holder's SSN:** ___-___-____

This information is required for all interest payments.

Policyholder/Certificate Holder Information: This * denotes a required field.

*Last Name | Suffix | *First Name | MI

Information on Deceased:

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy) | *Social Security Number | *Maiden Name/Nickname/Alias

*Home Address

*City | *State | *Zip Code

*Sex: ☐ Male ☐ Female

*Relationship to policyholder/certificate holder: ☐ Policyholder/Certificate Holder ☐ Spouse ☐ Dependent Child ☐ Other _____

Proof of Death Checklist

- Proof of Death - Physician's Statement- If this is a life policy/certificate less than two years old, this statement should be completed by the regular doctor of the deceased, not necessarily the doctor who attended the deceased at death.
- Authorization to Obtain Information- This form should be completed by the deceased's next of kin.
- Certified Death Certificate

Under the following circumstances, please send the additional items listed:

- If a minor is the beneficiary - A copy of the court order appointment of the legal guardian of the property and/or estate of any minor child. (Please note: custody does not qualify as guardianship.)
- If the beneficiary has died prior to the death of insured- A copy of the certified death certificate of the beneficiary.
- If the deceased was a dependent child over the age of 19, proof of full time student status may be required.

- Date of death: _____/_____/_____
- Place of death: _____
- Cause of death: _____

***Policy/Certificate Number:** | | | | | | | | |

***Policyholder's/Certificate Holder's SSN:** | | | | - | | | - | | | | |

This information is required for all interest payments.

Policyholder/Certificate Holder Information:

*Last Name	Suffix	*First Name	MI

Information on Deceased:

*Last Name	Suffix	*First Name	MI

- If death was due to an injury, please send a copy of the police report, toxicology/BAC report and answer the following questions.
  - Date of the injury: _____/_____/_____
  - Details of the injury: _____
- If death was due to a sickness, please answer the following questions.
  - When did the deceased first experience symptoms? _____/_____/_____
  - When did the deceased first consult a physician for this illness? _____/_____/_____
- Please provide the name and addresses of all physicians who attended deceased within three years prior to death:

Name	Address	Dates of Treatment	Disease or Condition

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Beneficiary's Signature*
**Guardian's Signature if beneficiary is a minor.*

Beneficiary's Printed Name

Date

Beneficiary's Date of Birth

Beneficiary's Social Security Number

Beneficiary's Phone Number

Beneficiary's Mailing Address

City, State

Zip Code

Witness' Signature

Witness' Printed Name

Date