

Life Insurance CLAIMANT STATEMENT

Return this form with:

1. Insurance Policy
2. Certified Death Certificate

To: P.O Box 833879
Richardson, TX 75083-3879

- Champions Life Insurance Company
- Central Security Life Insurance Company
- Western American Life Insurance Company
- _____

Name of deceased

List all policy numbers with this company

Date of birth

Date of death Place of death

From what record was birth obtained?

Cause of death

If any policy with this company was assigned, give particulars:

In last illness, when did deceased first consult physician?

- Please send IRS Form 712
(Life Insurance Statement for estate tax planning)

Name and address of physician(s) or hospital(s) who treated deceased during 5 years prior to death

The undersigned hereby makes claim to said insurance as beneficiary and agrees that the written statements and affidavits of all physicians who attended or treated the insured and all other papers called for by the instructions shall constitute and they are hereby made a part of these Proofs of Death, and further 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 is any insurance in force on the life in question nor a waiver of any of its rights or defenses.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility to furnish medical information concerning the deceased named above to the insurance company referenced above. Any and all information may be released, including but not limited to mental health records, drug and/or alcohol abuse records and/or HIV test results, if any except as specifically provided herein: _____.
The information may be used only for the purpose of adjudicating a life insurance claim. I understand this authorization is in effect for 180 days from the date of this authorization unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying the insurance company in writing and that the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

FRAUD WARNING: 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.

X _____
Signature of claimant / beneficiary / heir/ executor / power of attorney

Print claimant name Age Social Security # Relationship to deceased

Claimant's mailing address Phone number

X _____
Witness' signature (non-family member) Date Signed

Witness' address (street / city / state / zip)