

Liberty National Life Insurance Company

Insurance Services Division • P.O. Box 8066 • McKinney, Texas 75070

PROOFS OF DEATH — CLAIMANT'S STATEMENT

Please read carefully Instructions on Page 1 before completing this statement.

Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

1. Deceased's Name in Full _____

List any other names by which the deceased may have been known such as maiden name, hyphenated name, nick name, alias, or derivative form of first and/or middle name _____

2. Policy Number(s) _____

3. Deceased's Birth Date _____ 4. Date of Death _____ Cause of Death _____

5. Residence of Deceased at Death _____
Street Address City and State

6. **Is any policy less than two years old?** Yes No If "Yes," complete pages 2 and 3.

Signature: _____ Print Name: _____

Address: _____
Street City, State, ZIP

Social Security #: _____ - _____ - _____ Date of Birth: ___ / ___ / ___ Age: _____

Phone: Home (_____) _____ Work: (_____) _____ Email Address: _____

Relationship to Deceased: _____ Date: ___ / ___ / ___

Signature of Witness: _____ Print Name: _____

Signature: _____ Print Name: _____

Address: _____
Street City, State, ZIP

Social Security #: _____ - _____ - _____ Date of Birth: ___ / ___ / ___ Age: _____

Phone: Home (_____) _____ Work: (_____) _____ Email Address: _____

Relationship to Deceased: _____ Date: ___ / ___ / ___

Signature of Witness: _____ Print Name: _____

Give names and addresses of the physicians or other practitioners who, to your knowledge, attended the patient during the past five years.

Name	Address	Disease or Impairment	Name

INSTRUCTIONS

1. Claimant's Statement (Page 1) must be executed by the beneficiary or beneficiaries named in the policy. The Social Security Number is required for each claimant.
2. When the beneficiary is a minor, or is otherwise incapacitated, the Claimant's Statement (Page 1) must be executed by the guardian, with letters of guardianship attached.
3. If any named beneficiary in the policy has died before the insured, a death certificate of such deceased beneficiary must be attached.
4. Where the claimant is the executor or administrator of the estate of the insured, such person will complete Claimant's Statement (Page 1), and letters testamentary or letters of administration must be attached.
5. If the death of the insured was due to accident or homicide and any policy listed on Page 1 provides for accidental death benefits, a certified copy of the coroner's report, police report, dated newspaper reports, and all available information must accompany this proof of death. In addition, Page 3 must be completed.

STATEMENT OF PHYSICIAN

Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

This statement should be completed by the Insured's Primary Care Physician.

Full name of patient?	Name	Age
How long have you treated the patient?		
Were you the patient's medical attendant or adviser before last illness or infirmity? If so, when and for what disease?		
When was the patient diagnosed with the disease or impairment that resulted in death?		
Was the patient ever treated for drug or alcohol abuse? If so, please list dates and locations of treatment?		
Was the patient ever disabled? If so, when and for what reason?		
From what other disease or impairment has the patient suffered, and when?	Disease or Impairment	Duration
Was the patient confined to a hospital during the past 3 years? If so, provide name and address of the hospital.		
Give names and addresses of the referring physicians or other practitioners who, to your knowledge, attended the patient during the past five years.		
Name	Address	Disease or Impairment

Physician's Name (PRINT)

Street Address

Physician's Signature

City State Zip

(_____) _____
Fax Number

(_____) _____
Phone Number

AGREEMENT TO BE EXECUTED IN EVENT POLICY PROCEEDS ARE ASSIGNED

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 and is subject to criminal and civil penalties.

IT IS HEREBY AGREED by the subscribers hereto that Policies Nos. _____

issued or reinsured by Liberty National Life Insurance Company on the life of _____

have been duly assigned to _____ as collateral security; that there is now due to said

_____, Assignee, on account of said debt,

the sum of _____ Dollars (\$));

and that all claims under Policies may be settled by the payment of :

(A) _____ Dollars (\$)) to said

_____, Assignee, and (B) of the balance due on

and under Policies to _____, Claimant

IN TESTIMONY WHEREOF we have hereunto set our hands this _____ of _____, _____
day month year

_____, Assignee
Assignee's Tax ID # _____

Street Address

(_____) _____
Telephone Number

City State Zip

Witness _____, Claimant

NOTICE TO FUNERAL DIRECTOR:

If assigned amount exceeds \$5,000, a copy of the itemized bill must be attached.

INSTRUCTIONS

1. Claimant's Statement (Page 1) must be executed by the beneficiary or beneficiaries named in the policy. The Social Security Number is required for each claimant.
2. If part or all of the policy proceeds are assigned, the agreement at the top of Page 3 is to be executed by the beneficiary and assignee.
3. When the beneficiary is a minor, or is otherwise incapacitated, the Claimant's Statement (Page 1) must be executed by the guardian, with letters of guardianship attached.
4. If any named beneficiary in the policy has died before the insured, a death certificate of such deceased beneficiary must be attached.
5. Where the claimant is the executor or administrator of the estate of the insured, such person will complete Claimant's Statement (Page 1), and letters testamentary or letters of administration must be attached.
6. If the claimant is a partnership, Claimant's Statement (Page 1) should be completed in the name of the partnership by a general partner; and if claimant is a corporation, in the name of the corporation by an officer of the corporation with the corporate seal affixed.
7. If the death of the insured was due to accident, suicide or homicide and any policy listed on Page 1 is less than two years old or provides for accidental death benefits, a certified copy of the coroner's verdict or report of coroner's medical examiner, dated newspaper reports and all available information must accompany this proof of death.
8. **If policy is less than two years old, Page 4 must be completed.**