KEMPER Life

DEATH CLAIM - CLAIMANT'S STATEMENT

SUBMIT ALL CLAIM RELATED DOCUMENTS TO:
KEMPER LIFE INSURANCE SERVICES
12115 LACKLAND RD
ST. LOUIS, MO 63146
FAX: 314-819-4391
EMAIL: lifm28@kemper.com
*** Fax or email preferred**

Please use this form to submit a claim under a policy with one or more of the following Kemper Life companies: United Insurance Company of America, The Reliable Life Insurance Company, Union National Life Insurance Company, or Mutual Savings Life Insurance Company.

PLEASE TYPE OR PRINT THE FOLLOWING INFORMATION

1. DECEDENT/INSURED AND POLICY INFORMATION

Name of Insured (Deceased)_____ Social Security No. _____

List below any other names by which the Insured was known (include maiden name, nicknames, initials, common names, etc.)

(_____) (_____)(_____)

Date of Birth: _____ Date of Death: _____

Street Address of Insured: _____

City: _____ State: _____ Zip Code: _____

List any other states where the insured may have lived: _____

PROVIDE THE NUMBERS OF ALL POLICIES ON WHICH CLAIM IS BEING FILED:

2. BENEFICIARY/CLAIMANT INFORMATION

Name of Beneficiary/Claimant: _____ Relationship to insured: _____

Social Security #: _____ Phone #: (_____)_____ Date of Birth: _____

Mailing Address: _____

City: _____ State: ____ Zip Code: _____ Email address: _____

Name of Beneficiary/Claimant: _____ Relationship to insured _____

Social Security #: _____ Phone #: (_____)_____ Date of Birth: _____

Mailing Address: _____

City: _____ State: ____ Zip Code: _____ Email address: _____

3. ASSIGNMENT OF INSURANCE PROCEEDS

Have you or anyone else assigned or intend to assign any portion of the proceeds of any of the above-listed policies to a funeral home or any other party for the purpose of covering funeral expenses or for any other reason?

❑ Yes ❑ No If yes, provide the name and address of such firm or person: _____

_____

4. MANNER OF DEATH

❑ Natural Causes (such as heart attack, cancer, etc.)
❑ Accidental (such as motor vehicle accident, drug overdose, etc.)
❑ Homicide
❑ Suicide

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DEATH CLAIM - CLAIMANT'S STATEMENT (PART TWO)

5. DOCTOR/HOSPITAL INFORMATION

IF ANY POLICY IS LESS THAN TWO YEARS OLD OR IF THE DEATH WAS BY ACCIDENTAL MEANS, PLEASE COMPLETE THIS SECTION.
Please list any doctors, hospitals, or medical providers that treated the insured/deceased during the past five years. Should additional space be required, please include on an additional sheet of paper. If none are known, please indicate so.

Name of Doctor(s) or Hospital(s):_____ Telephone No.:_____

Address:_____ City: _____ State:_____ Zip Code:_____

Name of Doctor(s) or Hospital(s):_____ Telephone No.:_____

Address:_____ City: _____ State:_____ Zip Code:_____

Name of Doctor(s) or Hospital(s):_____ Telephone No.:_____

Address:_____ City: _____ State:_____ Zip Code:_____

6. MEDICAL AUTHORIZATION

Name of Insured: _____ Date of Birth: _____ Social Security #: _____

Upon presentation of this signed authorization or a copy thereof, I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy, dentist, coroner/medical examiner, insurance or reinsuring company, the MIB, Inc. (formerly the Medical Information Bureau) consumer reporting agency, employer, or other medical or medically related facility or other person or entity possessing medical or non-medical information or having any records or knowledge of the above-listed Insured or the Insured's health to give to the Claims Department of the appropriate Kemper Life company, or any authorized representative, any and all such information which may include but is not limited to drug, alcohol, psychiatric, HIV infection, or AIDS related information. I understand this information will be used to evaluate this life insurance claim and that failure to provide this authorization may impede the ability of Kemper Life to evaluate this claim. I understand I have the right to revoke this authorization at any time by submitting a written revocation except to the extent Kemper Life has taken action in reliance on the authorization. I understand that the information disclosed per this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA. I understand that this authorization is valid from the date of signing for the duration of this claim or as required by law. I understand that I am entitled to a copy of this authorization upon receipt of my written request to Kemper Life. I agree that a copy of this authorization shall be valid as the original.

Signature of Authorized Representative: _____ Date: _____

Printed Name: _____ Relation to Insured or Description of Authority:_____

7. CLAIM AUTHORIZATION

I/We affirm and declare the above and foregoing statements to be true and correct to the best of my/our knowledge and belief. I/We will furnish any additional proof the Company may request.

_____ _____
Signature of Beneficiary/Claimant Date Signed

_____
Relationship to Deceased

_____ _____
Signature of Beneficiary/Claimant Date Signed

_____
Relationship to Deceased