



SBLI USA Life Insurance Company, Inc.
S.USA Life Insurance Company, Inc.
Shenandoah Life Insurance Company
(Each the "Company")
Members of the Prosperity Life Group

CLAIMANT'S STATEMENT

INSTRUCTIONS FOR COMPLETING THIS FORM - Missing or incomplete information may delay claim processing. The paperwork requested below must be received in good order, all questions answered, dated and all necessary signatures and documentation furnished.

1. Claimant's Information - The named beneficiary should complete this form and sign before a witness who should also sign the form. If there is more than one beneficiary, each one must complete a separate form.

- If the beneficiary is an Estate, the form should be completed and signed by the Executor or Administrator of the Estate in his or her capacity as Executor or Administrator. Properly certified letters of administration must be submitted with the completed form.
If the beneficiary is a Trust, the form should be completed and signed by the Trustee of the Trust in his or her capacity as Trustee.
If the beneficiary is a minor, the form should be completed and signed by his or her legal appointed guardian in his or her capacity as Guardian. Certified letters of guardianship must be submitted with the completed form. In the event no guardian is to be appointed, contact the Company for further instructions.

2. Certified Death Certificate - Attach a certified death certificate showing cause of death for the insured.

3. Policy - Attach the insurance policy or policies pursuant to which claim is made (or certify that any policy not included is lost by your signature below).

INFORMATION ABOUT THE DECEASED

Name of Deceased in Full Date of Birth
Other Names Used by the Deceased

Please provide the Policy or Certificate Number(s) under which the claim is made:

Cause of Death Date of Death

Was the cause of death due to an accident? (If "Yes", additional documentation may be required)
Yes No

INFORMATION ABOUT THE CLAIMANT

You are completing this form as: Beneficiary Executor Administrator Trustee Date of Birth
Assignee Guardian Other: (Explain)

Name

Social Security Number (SSN) or Tax Identification Number (TIN) Male Female

PREFERRED PAYMENT METHOD

Please select a payment option below. Refer to attached Life Insurance Proceeds Payment Options for details. If you do not select an option, a lump sum check will be mailed to you.

- Lump Sum Payment placed into an Easy Option Account. Your benefit will be placed in an Easy Option Account opened in your name. The Account gives you full and immediate access to your benefit through a draftbook while you consider your longer-term financial decisions. You can write a draft for the full or partial balance of the account at any time. Please see the enclosed Summary of the Easy Option Account for more details. If you select this option and your claim is less than \$5,000 or this option is not available in your state, the Company will mail you a lump sum check.
Lump Sum Check.
Deferred Payment option. Please contact us and we will assist you in structuring your installment payments.

INTEREST PAYABLE ON INDIVIDUAL LIFE INSURANCE POLICIES ISSUED IN ILLINOIS: As provided by Illinois Insurance law, if payment is not made within 31 days from the date we receive due proof of death, interest at the rate of 10% from the date of death to the date of our payment will be included with the death benefit.

US TAXPAYER CERTIFICATIONS

Under the penalties of perjury, by signing below, I certify that:

- 1) The Taxpayer ID Number or Social Security Number provided on the prior page is my correct number (or I am waiting for a number to be issued to me), and
- 2) That I am not subject to back-up withholding because:
 - a.) I am exempt from back-up withholding, or
 - b.) I have not been notified by the Internal Revenue Service (IRS) that I am subject to a backup withholding due to failure to report all interest or dividends or
 - c.) The IRS has notified me that I am no longer subject to back-up withholding, and
- 3) I am a U.S. Citizen or U.S. person
- 4) I am not subject to FATCA reporting because I am a U.S. person and the account is located within the United States

NON-RESIDENT ALIEN STATUS - If you are a Non-Resident Alien, please check the box and provide your country of residence below. The amount paid will be subject to 30% withholding unless you submit an IRS Form W-8, and are entitled to claim a reduced rate of withholding under the applicable US tax treaty.

Under penalties of perjury, I certify that I am a Non-Resident Alien and my county of residence is: _____

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

CERTIFICATIONS AND SIGNATURES

By signing this form below, I certify that:

- All the information I have given is complete and true to the best of my knowledge and belief.
- I understand that if the Company overpays me, it has the right to recover the amount overpaid. This can occur if it is discovered that I was paid more than I am entitled to under this claim or that someone else was entitled to some or all of the proceeds. I understand that if I do not repay any such amount, the Company may take steps, including legal action, to recover overpayment.
- The original and any duplicates or certificates of each policy listed under which claim is made to be lost or otherwise unavaiaible unless sent to us with this Claimant's Statement.

I acknowledge that I have read the attached State Fraud Warning Notices. **New York Residents:** Any person who knowingly and with intent to defraud any insurance company or any 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 claim for each such violation.

Claimant's Name Capacity

Claimant's Authorized Signature Date

Claimant's Address _____
(Number and Street) (City) (State) (Zip Code)

Home Phone Number _____ Business Phone Number _____

Email Address _____

Witness Signature Date

Mail forms to:

SBLI USA Life Insurance Company, Inc.
100 West 33rd Street, Suite 1007
New York, NY 10001-2914
1-877-725-4872

S.USA Life Insurance Company, Inc.
P.O. Box 1050
Newark, NJ 07101-1050
1-866-787-2123

Shenandoah Life Insurance Company
P.O. Box 12847
Roanoke, VA 24029
1-800-848-5433, ext. 62059