Death Claim Package for Policy in Contestable Period

We offer our sincere condolences to the family in their recent loss. To begin processing the claim for benefits under this policy, we need the following documentation and forms completed and returned by the beneficiary.

CLAIMANT'S STATEMENT: Note: Must be signed by the Beneficiary and witnessed by a disinterested party or payment may be delayed. The claimant's statement does not need to be notarized.

AUTHORIZATION: Note: Must be signed by the Executor(rix) of the Estate or the Next of Kin. If signed by Executor(rix) please include a copy of the Letters Testamentary.

HEALTH STATEMENT: Note: Must be completed by the Next of Kin with the most knowledge of the insured's health history.

CERTIFIED COPY OF THE DEATH CERTIFICATE for the insured that identifies both cause and manner of death. Note: We cannot accept a photocopied death certificate for the insured person. A "certified" death certificate will have a "raised/embossed" or colored seal on the front. Generally, only one copy of the certified death certificate is necessary, even in the case of multiple beneficiaries. If any primary beneficiary pre-deceased the insured, we will require a photocopy of that beneficiary's death certificate. Death certificates become part of the file and cannot be returned.

ORIGINAL INSURANCE POLICY: Note: Please be sure to mark the Claimant's Statement where indicated if the policy is lost. If the claim is on a rider and the policy still provides coverage on additional individuals do **NOT** return the original policy. Please provide only a photocopy of the Policy Data Page and applicable insurance rider.

COPY OF THE OBITUARY (if available).

BENEFICIARY NAME CHANGE: Note: If the beneficiary's name changed after the owner designated the beneficiary, please return documentation of the name change (Marriage Certificate, Divorce Decree, etc.)

Please mail these documents to Americo Financial Life & Annuity Insurance Company, Attn: Claims, at one of the following addresses:

Regular Mail:	Overnight Mail:
PO Box 410288	300 W. 11th. Street
Kansas City, MO 64141-0288	Kansas City, MO 64105

Other than the original Claimant's Statement and Certified Death Certificate, faxed documents are generally acceptable and may be faxed to (800) 395-9238.

Because the death occurred during the contestable period, a routine investigation is necessary before a final determination can be made on this claim. To expedite the claim review and ensure prompt claim handling, please contact the Claims Department for information needed to properly complete the Health Statement. Proper completion of all forms will assist in avoiding delays in our review.

To assist with filing the claim, please read the Instructions to the Claimant Statement. If you have any additional questions or need further assistance, please contact our office at (800) 231-0801.

Sincerely,

Claims Department

Instructions & Claimant's Statement

CLAIMANT'S STATEMENT must be completed by the person(s) to whom the insurance is payable. If there is more than one beneficiary, you may make copies of this form as needed.

Please allow 10 business days from the date we receive all required information for processing of payment.

When a policy is payable to the Estate, the Claimant's Statement must be completed by the Executor(s) or Administrator(s), and submitted along with the Letters issued by the Court appointing that individual.

When a policy is payable to a company or corporation, the Claimant's Statement must be signed by two officers and include each officer's title.

When a policy is payable to a named beneficiary who is the age of majority or older, the statement must be made and signed by such beneficiary.

When a policy is payable to a minor, the statement may be made by the Court appointed Guardian of the minor's Estate and submitted along with a copy of the Court issued appointment or in accordance with other applicable state law. Proceeds may also be held with the Company at interest until the minor reaches the age of majority, which varies by state.

If a policy has been collaterally assigned by the owner prior to the death of the insured, a Statement of Interest is also required. This document provides a statement of the assignee's interest and may be obtained by contacting our office.

When an official inquiry as to the cause of death has been made, a certified copy of the medical report, verdict, or finding, must be furnished with this statement.

If any part of the proceeds of a policy is payable to "children" or to others of a designated class, an affidavit must be furnished giving the name and date of birth of each and stating that the persons named in the affidavit constitute all of the class designated in the policy. If any have died, the affidavit must give the date and place of death.

Form 712 may be requested at any time and will be provided upon completion of the claim payment.

PART A (INFORMATION ABOUT THE DECEASED)

Name of Deceased (State all names used by the deceased during their life including maiden name, nickname, alias, or other name)		Policy Number(s)
Deceased's Date of Birth	Deceased's Social Security Number	Date of Death
Deceased's Place of Birth		Cause of Death
List all policy numbers with this company:		If cause of death was other than natural: ☐ Suicide ☐ Homicide ☐ Accident

PART B (INFORMATION ABOUT THE BENEFICIARY)

Beneficiary Name (First, Middle, Last)		Telephone Number	
Mailing Street Address	City	State	ZIP
Beneficiary's SSN/Tax ID#	Date of Birth (Mo/Day/Yr)	Relationship to Deceased	

By my signature below I certify, under penalty of perjury, that the Social Security Number/ Tax I.D. identified above is correct. I further certify that ☐ I am or ☐ I am **NOT** subject to backup withholdings because (a) I am exempt, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholdings.

PART C (POLICY/DEATH CERTIFICATE) Please check the appropriate statements:

☐ Enclosed is a certified copy of the death certificate of the insured.
☐ I have enclosed the original policy(ies).
☐ After a diligent search, the original policy(ies), or copies, cannot be located
☐ If beneficiary is a trust, I have enclosed trust documents, which shows successor trustee.
☐ If beneficiary is a trust, I certify that the trust is still in full force and effect.

Note: Failure to return the certified death certificate and to check the appropriate boxes in Part C may delay payment. Death certificates cannot be returned.

Settlement Options (Please check one of the following options, initial your selection, and sign below)

Initial

☐ ____ Make proceeds immediately available*
☐ ____ I am interested in the Special Payment Options (e.g. Deposit, Installment or Life Income Options). Please send me additional information on these other options.
☐ ____ Other (please specify): _____

FRAUD

Several States require that a notice be provided to each claimant to protect against Fraud. The undersigned acknowledge the Fraud Notice document has been received, read and is incorporated by reference if the state I reside in is listed on that notice. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

The undersigned agrees that this statement constitutes claim for proceeds, if any, as was contractually in force at the time of the Deceased's death and that furnishing of this form does not waive any contract provisions.

_____ _____ _____ _____
Disinterested Witness Date Beneficiary Signature Date

_____
Witness Address and Phone Number

MUST BE SIGNED BY A WITNESS

*Unless a lump sum payment is specifically requested, policy proceeds totaling $5,000 or more will be automatically settled by an interest-bearing Financial Access Account for your benefit. Upon approval of your claim, you will receive a book of personalized drafts, which may be used immediately to access some or all of the policy's proceeds. You will have use of the account until your balance falls below $250, at which time it will be closed and the balance in the account plus accrued interest will be sent to you within 45 days. Although Financial Access Accounts are not FDIC insured, they are backed by the full strength and security of United Fidelity Life Insurance Company, the parent company of the life insurance companies owned or administered by Americo Life, Inc.

Fraud Notice Form

Many states require the Insurer to provide claimants with a Fraud Statement such as the following:

Any person who, with intent to defraud or knowing that the person 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.

The following states require the insurer to provide claimants with the specific language below:

ALASKA	A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
CALIFORNIA	For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
COLORADO	It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
DELAWARE	Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.
DISTRICT OF COLUMBIA	Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
FLORIDA	Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
IDAHO	Any person who knowingly and with intent to defraud, or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.
INDIANA	A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.
KENTUCKY	Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
MAINE AND TENNESSEE	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
MARYLAND	Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
MINNESOTA AND NEW HAMPSHIRE	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
NEW JERSEY	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
NEW YORK	Any person who knowingly and with intent to defraud any insurance company or 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 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 the claim for each such violation.
OHIO	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.

OKLAHOMA	WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete, or misleading information is guilty of a felony.
PENNSYLVANIA	Any person who knowingly and with intent to defraud any insurance company or 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 material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
PUERTO RICO	Any person who knowingly and with the intention to defraud, present false information in an application for insurance or, who presents, helps to present or makes someone present a fraudulent claim for the payment of a loss or another benefit, or who presents more than one claim for the same damage or loss, will incur a felony and if so convicted, shall be sanctioned for each violation with a fine not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, or a fixed jail term of three (3) years or both penalties. If there are aggravating circumstances, the established fixed penalty may be increased up to a term of five (5) years; if there are extenuating circumstances, it may be reduced to a minimum of (2) years.
RHODE ISLAND	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
TEXAS	Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
WASHINGTON	It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Health Statement

You can assist our office in handling this claim by completing the following information in full. To expedite the claim review and ensure prompt claim handling, please contact the Claims Department for information needed to properly complete the Health Statement. This form should be returned with the Claimant's Statement and Certified Death Certificate.

1. List the name(s) and address(es) of the Decedent's primary or family doctor. If the Decedent did not have a family doctor, please advise the name and address of the clinic/hospital where care would normally be sought:

_____

_____

_____

2. Did the Decedent have health insurance?..... ☐ Yes ☐ No

If Yes, please provide the name(s) and address(es) of the carrier(s) and policy number(s): _____

_____

_____

3. Had the Decedent been in any hospital within the specified time period?..... ☐ Yes ☐ No

If yes, please provide name of hospital and dates of service:

_____

_____

_____

4. Did the Decedent use any prescription medication prior to death? ..... ☐ Yes ☐ No

If Yes, what medicines? _____

_____

_____

5. What is the name and address of the pharmacy used to fill prescriptions? _____

_____

6. The Decedent died as a result of: _____

If the death resulted from illness or disease please provide the following:

A. Date the underlying condition causing death was first treated: _____

B. Name and address of doctor/clinic first treating: _____

_____

7. To your knowledge did the Decedent smoke cigarettes or use other tobacco products prior to their death? ..... ☐ Yes ☐ No

If Yes, please list average quantity consumed: _____

8. Did the Decedent use medication or receive treatment for:

A. Diabetes	☐ Yes	☐ No	E. Alzheimer's Disease	☐ Yes	☐ No
B. Heart Disease	☐ Yes	☐ No	F. Emphysema	☐ Yes	☐ No
C. Stroke	☐ Yes	☐ No	G. Kidney Disease	☐ Yes	☐ No
D. Cancer	☐ Yes	☐ No	H. Alcohol or Drug Treatment	☐ Yes	☐ No

For any Yes response(s) above, please note the question letter and provide details about the prior care below.

_____

_____

_____

_____

_____

_____

_____

9. Print the full name, address, and phone number of the Decedent's employer: _____

_____

_____

10. Decedent's occupation: _____

11. Date last worked: _____

12. Facts concerning other life, health and accident insurance carried by the Decedent.

Company Policy Date Amount of Insurance

_____

_____

_____

I declare that the facts stated on this form are complete and true to the best of my knowledge and belief.

Warning: A person who knowingly and with intent to injure, defraud, or deceive an insurance company, files a claim containing false, incomplete or misleading information, may be guilty of a felony or misdemeanor.

_____ _____ _____

Signature Relationship to Decedent Date

Authorization and Consent to Disclosure

This form is HIPAA compliant

Policy Number: _____

Insured: _____

Purpose of Authorization: Process Insurance Claim

HOME OFFICE USE ONLY		
Records Provider		
Name of Insured	Date of Birth	Social Security Number of Insured
Type of Records to be Released:		
Time Period of Requested Records: _____ to _____		

I/We authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy, or other medical related facility, insurance company, employer, Social Security Administration, the Medical Information Bureau ("MIB"), or any other person, organization or institution that may have records or information about me (our), or my (our) minor children who are insured to provide the Company, its authorized representative or its reinsurers, any and all medical (including entire medical, psychiatric/psychological, AIDS/AIDS related), alcohol and drug (including both illegal and prescription drugs) related records and information), criminal, and/or driving records or knowledge, to assist in determining insurability or eligibility for benefits.

The Company may release information obtained by this authorization to its reinsurers, to the MIB, to other insurers with whom I (we) have policies or to whom I (we) may submit a claim, to other persons performing business or legal services in connection with an insurance transaction for me (us) or as may otherwise be lawfully required. I/We understand that disclosure of information to the Company may subject the information to redisclosure in accordance with the Company's privacy policy. It is the Company's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or re-using such information, except as may be done lawfully.

This authorization shall be valid for 24 months from the date of application. This authorization may be revoked; however, it may not be revoked to the extent that the Company has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to the Company at its Home Office address. A photocopy of this document shall be as valid as the original.

_____ _____

Signature (must be next of kin or Executor(rix) of Estate) Date

_____ _____

Relationship Initial here if the Estate of the Insured has not and will not be probated.