



## Proof of Death Beneficiary's Statement

POLICY # \_\_\_\_\_

CLAIM # \_\_\_\_\_

1. Deceased's Name \_\_\_\_\_  Married  Divorced  
 Never Married  Widow(er)

First Middle Last  
Birth \_\_\_\_\_  
Date

Death \_\_\_\_\_  
Date Place Cause of Death

Deceased's Social Security Number: \_\_\_\_\_

2. Did death occur as a result of accidental bodily injury?  Yes  No

3. Did you enclose the above policy?  Yes  No

4. Did the above policy get lost or destroyed?  Yes  No

If you answered yes to this question, the Company shall be free of all liability under the original policy **after** this claim has been paid.

\_\_\_\_\_  
Beneficiary's Signature

\_\_\_\_\_  
Beneficiary's Name (Type or Print) Age

\_\_\_\_\_  
Beneficiary's Social Security Number or Taxpayer ID

\_\_\_\_\_  
Beneficiary's Box Number or Street Address

\_\_\_\_\_  
Witness

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number