Dearborn National®

Underwritten by Dearborn National® Life Insurance Company
Phone Number: 800.538.0379
Fax Number: 866.488.5965

Request for Payment of Death Benefit

Administrative Office:
P.O. Box 19106
Greenville, SC 29602

PLEASE READ INSTRUCTIONS on page 2 of this form

This form is supplied by **Dearborn National® Life Insurance Company** upon request without verification of the status of the insurance. Verification will be made upon receipt of the completed form at the Home Office.

STATEMENT OF PERSON REQUESTING PAYMENT

Please list the Dearborn National® Life Insurance Policy numbers under which payment is requested?

Number(s): _____ _____ _____

_____ _____ _____

1. Name of Insured in full **(Please Print)**:	8. Are you the beneficiary named in the policy? ☐ Yes ☐ No (If not, state in what capacity you request payment.)
2. Insured's Date and Place of Birth:	9. Are you entitled to receive the entire amount payable on the policy? ☐ Yes ☐ No (if no, how much of the amount?)
3. Date and Place of Death **(If hospital, give name & address):**	10. What is your date of birth?
4. Address of Insured's last residence:	11. Names, Addresses & Birth Dates of other beneficiaries or payees: _____ _____ _____ _____
5. Occupation of Insured at Death - date last worked:	
6. Principal Cause of Death:	12. Please list all other insurance on the life of the insured. COMPANY _____ Amt ($) _____
7. When did health of Insured first begin to be affected?	COMPANY _____ Amt ($) _____ COMPANY _____ Amt ($) _____

13. **In order to avoid a delay in processing, attach the original policy to this form or initial below as certification of lost policy.**

_____ I/We certify that the above numbered policy has been lost or destroyed, and, to the best of My/Our knowledge, is not in anyone's possession. If the policy is located after the completion of this request, it will be returned to the Administrative Office immediately without any additional rights, claims, or demands made under this policy.

I have read any attending physician's statement furnished by me herewith and ask that it be made a part of this request.

AUTHORIZATION

Permission is hereby given to any physician or practitioner, hospital, or other institution, to give an authorized representative of Dearborn National® Life Insurance Company full details as to treatment, diagnosis, and past medical history, and to furnish copies of the records (if requested by such representative) in connection with the case of _____.
(A copy of this authorization is to be equally acceptable.)

Date: _____

NAME OF PERSON REQUESTING PAYMENT: _____

SIGNATURE OF PERSON REQUESTING PAYMENT: _____

Address: _____ Phone #: _____

City/State/Zip: _____ SS#: _____

R110415 I A518_g

Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

Phone Number: (800) 538-0379
Fax: (866) 488-5965

Preference Beneficiary's Affidavit

Administrative Office:
P.O. Box 19106
Greenville, SC 29602

Policy Number	Claim Number	Name of Deceased	IF MORE SPACE IS NEEDED ATTACH A SIGNED AND DATED SHEET IN THE SAME FORMAT SHOWN BELOW

Note: This affidavit is to be used whenever no beneficiary was designated or no designated beneficiary survived the deceased. It is to be completed only by the person or one of the persons within the first surviving class of the following classes of successive preference beneficiaries of the deceased: 1) widow or widower; 2) child(ren); 3) parents; 4) brother(s) or sister(s); 5) executor or administrator.

State or Province of _____)

County of _____)

I, _____, residing at _____
(Street Address) (City or Town) (State) (Zip)

being first duly sworn, depose and state:

I am providing the information in this affidavit knowingly and with the understanding Dearborn National® Life Insurance Company will rely on it in paying the claim involving the above named deceased insured. I am knowledgeable about the heirs of the above named deceased insured. The below information is true, correct and complete.

WIDOW OR WIDOWER

That I am the surviving spouse of the deceased person named above.

The date of my birth is: / /

Soc. Security # _____ Phone # _____

_____
(signed)

SON OR DAUGHTER

That the deceased person named above left no surviving spouse; that I am a natural or adopted child of the deceased; and that the deceased left no surviving natural or adopted children other than myself and those listed below:

Name	Address	Date of Birth	Soc. Security #	Phone #

The date of my birth is: / / Soc. Security # _____ Phone # _____

_____
(signed)

FATHER OR MOTHER

That the deceased person named above left no surviving spouse or natural or adopted child; that I am a parent of the deceased; and that the other parent is listed below:

Name	Address	Date of Birth	Soc. Security #	Phone #

_____
(signed)

R010714 I a5770

Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

Phone Number: (800) 538-0379
Fax: (866) 488-5965

Preference Beneficiary's Affidavit

Administrative Office:
P.O. Box 19106
Greenville, SC 29602

BROTHER OR SISTER

That the deceased person named above left no surviving spouse, natural or adopted child, or parent; that I am the brother/sister of the deceased; and that the deceased left no surviving brothers or sisters other than myself and those listed below:

Name	Address	Date of Birth	Soc. Security #	Phone #

The date of my birth is: / / Soc. Security #_____ Phone _____ #_____

_____
(signed)

EXECUTOR OR ADMINIS-TRATOR

That the deceased person named above left no surviving spouse, natural or adopted child, parent, brother, or sister; and that I am the executor or administrator of the estate of the deceased.

_____
(signed)

THIS FORM MUST BE NOTARIZED

Subscribed and sworn to before me this _____day of _____,20___.

It is further understood and agreed that Affiant on behalf of himself or herself and on behalf of any surviving members of Affiant's class of surviving preference beneficiaries and any heirs, executors, administrators and assigns hereby releases and forever discharges Dearborn National®, its successors and assigns from any and all actions, causes of action, claims and demands they may now have or may hereafter have against Dearborn National Life on account of this claim or policy, or arising from any matter in connection with said claim or policy. Further Affiant agrees to save and keep harmless Dearborn National Life Insurance Company from any and all causes of action that may be made against Dearborn National Life Insurance Company by the Estate and the executors and administrators or the heirs of the deceased or any other claimant on account of said claim or policy or on account of payment of the proceeds as provided herein.

I, the undersigned, a notary public in and for said county in said state, hereby certify that _____ whose name is signed to the foregoing instrument, and who is known to me, acknowledged before me on this day that, being informed of the contents of said instrument, he/she executed the same voluntarily on the day the same bears date.

(SEAL)

_____
Notary Public or other official authorized to administer oath

My commission or term expires _____

R010714 I a5770