Beneficiary Claimant Statement

Please check the box next to your insurance company's name.

❑ American States ❑ Central United Life ❑ First Unum
❑ Gold Cross Burial Association ❑ Investors Consolidated ❑ Unilife
❑ Loyal American ❑ Manhattan Life ❑ Unum ❑ Family Life ❑ Sun America

IMPORTANT: READ THE INSTRUCTIONS ON THE NEXT PAGE BEFORE COMPLETING THIS STATEMENT.

Beneficiary Information	
Beneficiary Name	Beneficiary Date of Birth
Beneficiary Address	
Beneficiary SSN or TIN	Beneficiary Daytime Telephone Number

Insured Information	
Full Name of Insured	Date of Death (Month, Day, Year)
Last Address of the Insured (Street, City, State, ZIP)	
Place of Death (Residence or Hospital, City, ST, ZIP)	

1. What relationship do you claim to the insured? _____
2. The EXACT birth date of insured was _____
3. The DIRECT CAUSE of death was _____
4. Was death due to suicide? _____
5. Was any inquest or investigation held? _____
   If so, attach a certified copy of all evidence and the verdict as part of these proofs.

I, the claimant, being duly sworn, state that the deceased was the holder of, and I have read, Policy Number(s) _____ in the Life Insurance Company indicated above, and this claim is made under all the provisions thereof; that the answers to the questions and the statements hereinafter set out are full, true, and complete in every particular.

A Certified Copy of the standard certificate of death and the Policy are hereto attached.

In presenting these Proofs of Death I affirm that the insurance is legally due to me; that I have answered all the questions personally, without evasion or reservations, withholding nothing that would affect the status of any claim made for insurance hereunder. I agree that the written statements and affidavits of all Physicians or others who attended, treated, or had knowledge of deceased and all other papers called for by the Company, including records of Hospitals or Sanitariums shall constitute and they are hereby made part of these Proofs of Death. I further agree that the furnishing of these forms, or of any other matter supplemental thereto, by said Company shall not constitute, nor a waiver of any of its rights or defenses. I hereby authorize any Physician, Hospital or other persons to give the Company any information concerning the health or insurability of the deceased, and hereby specifically waive all grounds of defense or objection based on rights of confidential relationship or privileged communication between Physician or Hospital and Patient.

New York Residents: 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 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 the claim for each such violation.

_____
(Signature of Beneficiary/Guardian/Trustee/Executor)

State of _____ County of _____

Before me, _____(notary public's name) a notary public, on this day personally appeared _____, known to me (or proved to me on the oath of _____) to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he/she executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ (day) day of _____ (month), _____ (year).

_____
Signature

My Commission Expires

(Personalized Seal)

Submit Completed Form to:
Claims Department
P.O. Box 925309, Houston, TX 77292-5309
Customer Service Department 1-800-669-9030
Customer Service Department for Family Life 1-800-877-7705

LIFE-CLM-1010

MANHATTAN

ACKNOWLEDGMENT OF MISPLACED POLICY

Please check the box next to your Insurance Company's (Company) name.

❑ American States ❑ Central United Life ❑ First Unum ❑ Investor's Consolidated
❑ Western United Life ❑ Gold Cross Burial Association ❑ Unilife
❑ Loyal American ❑ Manhattan Life ❑ Unum ❑ Family Life ❑ Sun America

Policy Number: _____

Issued Date: _____

To the best of my knowledge and belief, I am personally not in possession of the above referenced policy; and, to the best of my knowledge and belief, the above referenced policy has not been delivered to any person having any right, title, or interest in it. I agree and understand that if the original policy is found by me, I will immediately return it to the Company.

_____ _____
Signature of Owner/Beneficiary/Claimant/Guardian/Trustee/Executor Date

_____
Printed Name of Owner/Beneficiary/Claimant/Guardian/Trustee/Executor

_____ _____
Signature of Witness Date

_____
Printed Name of Witness

Submit Completed Form to:
Policy Holder Services
P.O. Box 925989
Houston, TX 77292

AD2007

Customer Service Department 1-800-669-9030

MANHATTAN