CLAIMANT'S STATEMENT

Unity Life Insurance Company
PO Box 5000, Syracuse, NY 13250-5000 • Shipping (Including UPS, FedEx, etc.): 507 Plum St., Syracuse, NY 13204
315-448-7000 • Fax 315-448-7100 • Toll Free 1-800-836-7100

unity life

Section A - Information about the **Insured/annuitant:** PLEASE DO NOT LEAVE ANY QUESTION (1-5) BLANK

Policy Number(s)

_____ _____ _____ _____

1. Name: _____ 2. Date of Birth: _____
First M.I. Last Mo. Day Yr.
2. Maiden Name/Other names known by: _____
4. Insured Social Security Number: _____
5. Address: _____
Street Apt. No. City State Zip Code

Section B - Information About **You**, the Claimant:

1. Your Name: _____ 2. Your Date of Birth: _____
First M.I. Last Mo. Day Yr.
3. Your Address: _____
Street Apt. City State Zip Code
4. Your Telephone Number: Evening ( )_____-_____ Day ( )_____-_____
5. Your Relationship to the Insured/Annuitant: _____
6.

Enter your taxpayer identification number in the appropriate box. For most individuals this is your social security number.	Social Security Number (S.S.N.)	OR	Tax Identification Number (T.I.N.)

CERTIFICATION: - Under penalties of perjury I certify that
(a) The number shown on this form is my correct Taxpayer Identification Number and
(b) To the best of my knowledge, I am not subject to backup withholding. [If you are subject to backup withholding, cross out the words after (b)].

Section C - Lost Policy: ☐ Policy Enclosed ☐ Policy Lost

If the policy is available it MUST be submitted to Unity with this form.
If the policy does not accompany this form, I certify that it has been lost or mislaid and I agree to send it to the Company if found. Furthermore, I agree that for myself, my heirs, executors, assigns and administrators, the Company is released from further claim under this policy with regard to any action Unity may take in reliance on this lost policy certification.

Section D - Authorization for Release of Information:

NAME OF INSURED: _____

TO PHYSICIANS OR PRACTITIONERS, HOSPITALS, CLINICS, PHARMACISTS, INSURANCE COMPANIES, MEDICAL INFORMATION BUREAU, EMPLOYERS AND OTHER PERSONS OR INSTITUTIONS: This authorizes you to give Unity Mutual Life Insurance Co. or its authorized representative who is employed to assist in the evaluation of the claim on the above individual, any information, data or records you may have regarding this individual, his/her employment or condition (including records pertaining to psychiatric, drug or alcohol use history, and any disability he/she may have had). I understand that any information obtained pursuant to this authorization will be used to evaluate this claim, unless I revoke it by writing the Company. I understand I have the right to request a copy of this authorization and that a copy will be sent to me if requested. A photocopy of this authorization may be accepted by you.

Section E - Your Signature. I have read this form carefully and certify that all information contained in it is accurate and complete to the best of my knowledge.

_____ _____

Your Signature Date

Complete Below Only if Policy Was Less Than 2 Years Old, or Accidental Death Involved

State of _____ City of _____ County of _____

On this _____ day of _____ ____ before me personally came _____ to me known and known to me to be the individual described in and who executed the foregoing authorization, and he/she duly acknowledged to me that he/she executed the same.

_____

Notary Public - Commissioner of Deeds

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 $5,000 and the stated value of the claim for each such violation.

For New Jersey residents only: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.