Senior Life Insurance Company
P.O. Box 2447
Thomasville, GA 31799-2447
1-877-777-8808
A Georgia Stock Company • Executive Offices: Thomasville, Georgia

Claim Form

AUTHORIZATION – MEDICAL INFORMATION FOR FILING A DEATH CLAIM

"I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility or insurance company that has records or knowledge of the deceased or the deceased's health to give to the Claims Department of Senior Life Insurance Company or its reinsurers any such information including mental, alcohol, drug, or AIDS related information for the purpose of assessing the pending claim. This authorization may be used for the duration of the pending claim. I may request and receive a copy of any medical information obtained with this authorization. A photostatic copy of this authorization shall be as valid as the original. I declare that I am of legal age to file this claim."

_____ Name of Deceased

_____ Next of Kin (print name)

_____ Policy #

_____ Street Address

_____ Relationship to Deceased

_____ City State Zip

If death has occurred within 2 years of issue/reinstatement date or if the death was by Accidental means, list the doctors/hospitals that treated the insured in the **5 years prior to the application date.**

Primary

Doctor _____

Address _____

City _____ St_____Zip _____

Phone (_____)_____

Doctor _____

Address _____

City _____ St_____ Zip _____

Phone (_____)_____

Hospital _____

Address _____

City _____ St_____Zip _____

Phone (_____)_____

Clinic _____

Address _____

City _____ St_____ Zip _____

Phone (_____)_____

Dated this _____ day of _____, _____

X_____
Signature of Next of Kin

PLEASE COMPLETE THE APPROPRIATE INFORMATION ON REVERSE SIDE OF THIS FORM.

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fradulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

BENEFICIARY INFORMATION

Name of Beneficiary _____ Relationship _____

Address _____ City _____ St _____ Zip _____

Social Security # _____ Phone # (_____)_____ Date of Birth _____

Name of Beneficiary _____ Relationship _____

Address _____ City _____ St _____ Zip _____

Social Security # _____ Phone # (_____)_____ Date of Birth _____

ASSIGNMENT OF PROCEEDS OF INSURANCE

I, _____, being entitled to receive benefits under Policy # _____
(Beneficiary)

issued by Senior Life Insurance Company on the life of _____,
(Deceased/ Insured)

now deceased, and having contracted with and being indebted to _____
(Funeral Home)

of _____ for funeral services and merchandise for the deceased, do
(Address, City, State, Zip)

hereby set over, assign and transfer unto said Funeral Director the sum of _____

Dollars ($_____) out of the proceeds of said Insurance Policy; and I hereby authorize and direct Senior Life Insurance Company to make its check payable to said Funeral Director for the assigned amount and to pay the remainder of the proceeds of said Insurance Policy, if any, to me.

_____ _____ **NOTARY SEAL**
(Beneficiary Signature) (Beneficiary Signature)

Sworn and subscribed before me the _____ day of _____, _____

NOTARY PUBLIC _____ My commission expires _____

AFFIDAVIT FOR LOST POLICY

I, the undersigned, hereby certify that Policy # _____ issued on the life of _____ by the Company has been lost or destroyed.

Beneficiary Signature _____ Date _____

BENEFICIARY CERTIFICATION

Checklist:

❒ Certified Death Certificate ❒ Original Policy/Affidavit for Lost Policy ❒ Claim Form ❒ HIPAA Form

By signing below I, the Beneficiary, certify that the statements in this form are true to the best of my knowledge and that all necessary paperwork has been completed according to the above checklist.

Beneficiary Signature _____ Date _____

Beneficiary Signature _____ Date _____