Senior Life Insurance Company
P.O. Box 2447
Thomasville, GA 31799-2447
1-877-777-8808

A Georgia Stock Company • Executive Offices: Thomasville, Georgia

Claims 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 any records or knowledge of the deceased or the deceased's health to give to the Claims Department of the Company or its reinsurers any such information including mental, alcohol, drug or HIV 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 _____ Doctor _____

Address _____ Address _____

City _____ St_____ Zip _____ City _____ St_____ Zip _____

Phone (_____)_____ Phone (_____)_____

Hospital _____ Clinic _____

Address _____ Address _____

City _____ St_____ Zip _____ City _____ St_____ Zip _____

Phone (_____)_____ Phone (_____)_____

Dated this _____ day of _____, _____ **X**_____
Signature of Next of Kin

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

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony.

BENEFICIARY INFORMATION

Name of Beneficiary _____ Social Security # _____

Address _____

Phone number (_____)_____ Date of Birth _____

Name of Beneficiary _____ Social Security # _____

Address _____

Phone number (_____)_____ Date of Birth _____

ASSIGNMENT OF PROCEEDS OF INSURANCE

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

issued by _____ on the life of _____,
(Insurance Company) (Deceased)

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

_____ for funeral services and merchandise for the deceased, do
(Address)

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 said 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.

Checklist:
❒ CL3207 ❒ Certified Death Certificate ❒ Original Policy/Affidavit for Lost Policy ❒ HIPAA

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 _____ Date _____

Beneficiary _____ Date _____