LIBERTY NATIONAL LIFE INSURANCE COMPANY

CLAIMANT'S STATEMENT

For your protection, laws in certain jurisdictions require the following to appear on this form. "Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

INSTRUCTIONS FOR FILING A DEATH CLAIM

1. If the policy is $10,000 or LESS and has been in force for more than two (2) years, complete Parts A and C, and submit along with an obituary.
2. If the policy is OVER $10,000 and has been in force for more than 2 years complete Part A and submit with a certified death certificate and an obituary.
3. If the policy has been in force for LESS than 2 years or provides accidental death benefits, complete Parts A & B, sign the enclosed authorization, and have the family physician complete the enclosed Statement of Physician.

PART A

Date of Death:_____

Deceased's Name in Full: _____

(List any other names by which the deceased may have been known such as maiden name, hyphenated name, nickname, alias, or derivative forms of first and/or middle name.)

List all policy numbers: _____

Claimant's Signature:_____ **Date:** _____ **SSN:** _____
Address: _____ **DOB:** _____
Home Phone:_____ **Other Phone:**_____

Claimant's Signature:_____ **Date:** _____ **SSN:** _____
Address: _____ **DOB:** _____
Home Phone:_____ **Other Phone:**_____

PART B Medical Statement

You should complete this Statement only if any coverage was in effect less than two years prior to the insured's death.

NAMES AND ADDRESSES OF ALL PHYSICIANS/HOSPITALS WHO TREATED THE DECEASED IN THE PAST 5 YEARS.			
Name	**Address**	**Date**	**Reason**

The family physician most familiar with the medical history should complete the enclosed Statement of Physician.

PART C Proof of Death

This section may be completed by Funeral Director or Coroner and submitted with an obituary if the policy is $10,000 or less and has been in force for more than two years. A certified death certificate may be submitted as alternate proof of death.

Full name of deceased:	**Date of death:**
Residence at death:	**Place of death:** *If hospital or institution, give name*
Marital status:	**Date of birth:**
Next of Kin:	**Next of Kin's address:**

Signature of Funeral Director or Coroner: _____ Name of Funeral Home: _____

Address: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Authority to Release Protected Health Information:

I hereby authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, the Social Security Administration or other health care provider that has provided payment, treatment, or services on the insured's behalf, to release the medical records indicated below to Liberty National Life Insurance Company.

Information To Be Released:

Medical Records from (date) _____ to (date) _____

Type of Information to be released:

X	Medical Records for above period.	**X**	Clinical records.
X	History, Physical & Discharge Summaries.	**X**	Emergency room/Outpatient records.

_____ Other (Specify): _____

Purpose of the Requested Disclosure of Protected Health Information:

I authorize the release of the above referenced Personal Health Information and any other protected health information to Liberty National Life Insurance Company for the purpose of determining the eligibility of or administration of claims. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol and drugs. I understand that any information disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. This authorization shall remain in force 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time by submitting a written request to the Administrative Office of Liberty National Life Insurance Company.

Name of Insured: _____

Date of Birth: _____ Policy Number: _____

Signature of Beneficiary or Executor/Personal Representative: _____

Date: _____ Relationship to Patient: _____

Policy Number: _____

STATEMENT OF PHYSICIAN

This statement should be completed by the Family Physician only if any coverage was in effect less than two years prior to the Insured's death.

Full name of deceased?	Name: Age:	
How long have you treated the deceased?		
Were you the deceased's medical attendant or adviser before last illness or infirmity? If so, when and for what disease?		
When were you first consulted by deceased for the condition which either directly or indirectly caused death?	Date: By Whom:	
Was deceased referred to you by another physician within the past two years? If so, name and address of referring physician.	Physician Name: Address:	
Did death occur in a hospital or institution? If so, give name and location.		
Was the deceased confined to a hospital during the past 3 years? If so, provide name and address of the hospital.		
How long, in your opinion, did deceased suffer from the disease or impairment that resulted in death?		
What were the contributory causes of death? (Give as many as you can, by dates, and the duration of each.)	Disease or Impairment:	Duration:
From what other disease or impairment has the deceased suffered, and when?	Disease or Impairment:	Duration:

Give names and addresses of all other physicians or other practitioners who, to your knowledge, attended the deceased during the past five years.

Name	**Address**	**Disease or Impairment**

Physician's Name (Please Print): _____

Physician's Signature: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: (_____) _____