PROOFS OF DEATH SUBMITTED TO

AMERICAN INCOME LIFE INSURANCE COMPANY

P.O. Box 15446 • New Lynn, Auckland NZ

CLAIM BY BENEFICIARY STATEMENT

NOTE: This side is to be completed by the beneficiary of the policy and sent, along with the death certificate, to the above address. Be sure to look at the instructions at the top of the form on the reverse side to see if it must also be completed.

Policy Numbers

INFORMATION ABOUT DECEASED

Deceased's name	Date of death
Deceased's address	Place of death (If hospital or institution, give name)
Deceased's occupation	Cause of death
Deceased's union and local #/credit union affiliation	Did death result from: Suicide? ☐ Homicide? ☐ Accident? ☐
Deceased's birth date	If answered yes to Homicide or Accident, please forward copies of accident and/or police report. Also enclose any pertinent newspaper articles.
When did deceased first complain or give other indication of last illness?	When did deceased first consult a physician for last illness?

Give the name and address of physicians who treated deceased during the 5 years prior to death:

Name	Address	Disease or condition	Dates

INFORMATION ABOUT BENEFICIARY

Beneficiary's name	Beneficiary's relationship to Insured
Beneficiary's address	Beneficiary's telephone number
	Beneficiary's Social Security Number
Is the policy attached? ☐ Yes ☐ No If no, reason not attached:	Beneficiary's birth date
	E-mail Address

Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

I hereby authorize and request any licensed physician, medical practitioner, hospital (including VA hospital), clinic or other medical related facility, insurance company, the Medical Information Bureau, or other organization to permit bearer or representative to view, copy, be furnished copy or be given detail of all record information in connection with any past or present illness, injury, treatment, consultation or medical history of the deceased in behalf of the American Income Life Insurance Company. Information received is for the purpose of evaluating this claim and determining our liability under existing coverage with American Income Life Insurance Company. This authorization shall remain valid for one year. A photographic copy of this authorization shall be as valid as the original.

Date _____ Signature of beneficiary _____

PROOFS OF DEATH SUBMITTED TO

PHYSICIAN'S STATEMENT

AMERICAN INCOME LIFE INSURANCE COMPANY

P.O. Box 15446 ● New Lynn, Auckland NZ

Completion of this side of the form is required if the policy (or any rider added to the policy) is less than two years old or if the policy (or any rider added to the policy) has been reinstated within the last two years. If completion is required, please ask the physician who treated the last illness of the deceased to complete this side of the form before you mail it to the Company.

Deceased's name	Date of death

Cause of death *(Enter only one cause for each of a, b, and c.)*	Interval between onset and death
Disease or condition directly leading to death: *(This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)*	
(a) _____	(a) _____
Antecedent causes. *(Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.)*	
Due to (b) _____	(b) _____
Due to (c) _____	(c) _____
Other significant conditions: *(Contributing to the death but not related to the disease or condition causing death.)*	

Date of First Attendance in Last Illness	Date of Last Attendance in Last Illness

If death was due to accident, suicide or homicide, specify which. Describe briefly.	Was an inquest held? ☐ Yes ☐ No Was an autopsy performed? ☐ Yes ☐ No If so, by whom and with what findings?

Have you treated or advised the deceased during the 5 years prior to last illness? ☐ Yes ☐ No

Did the deceased, to your knowledge, receive treatment during such 5 years from any other Physician, or in any Hospital or Institution? ☐ Yes ☐ No

If Yes to either question, please furnish the following:

Name of Physician or Hospital	Address	Disease or Condition	Dates

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Date _____

Signature of physician _____

Address _____