

CLAIM INSTRUCTIONS

Please review these instructions as you complete the enclosed Claimant Statement. If you need any assistance, please call us, toll-free at (800) 221-2554.

- All sections of the Claimant's Statement must be filled out completely by the Claimant (the beneficiary). The Claimant must sign the bottom of the form and the signature must be notarized. If there is more than one Claimant, each beneficiary must complete a separate form.
- When the beneficiary is a minor, incapacitated, or is unable to sign, the person empowered to act for the beneficiary must sign the Claimant's Statement. (Supporting documents; i.e., Power of Attorney, Certified Letter of Guardianship of the beneficiary's estate or Conservatorship Appointed must be attached to the Claimant's Statement). The Claimant's Statement must include the Social Security number of the minor child or incapacitated beneficiary.
- If the Claimant is the executor or administrator of the estate of the insured or the trustee for a beneficiary, such person must complete the Claimant's Statement. Certified Letters Testamentary, Letter of Administration or Trust Document must be attached. The tax identification number of estate or trust is required.
- The certified death certificate must display the colored emblem or raised seal of the issuing authority. If any Primary beneficiary named in the policy has died before the insured, a certified death certificate of the beneficiary must be attached.
- All documents sent to us, including but not limited to the certified death certificate, become a part of the claim file and cannot be returned to you.

Payment Methods and Options for Claim Proceeds:

You may choose to receive one check for the entire amount of the proceeds.

For payments under \$2,500, a check will be issued.

For payments of \$2,500 or more you may choose one of the settlement options described in the policy, unless the policy specifies a different amount. The policy may include settlement options which provide fixed interest rates ranging from 2% to 3.5%. Please refer to the policy contract and review all the settlement options that may be available to you.

Important Reminders

- ◆ Each section of the Claimant's Statement must be completed.
- ◆ The Claimant's Statement must be signed and notarized.
- ◆ Provide additional required documentation (e.g. letters testamentary, trust documents, letters of administration).
- ◆ Provide a certified Death Certificate

Claim Fraud Warning Statements by State

The following statements represent the law in each respective state and are required to be provided by the Company:

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

ARIZONA: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, LOUISIANA, RHODE ISLAND and WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to the settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

DISTRICT of COLUMBIA: WARNING: It is a crime to provide false or misleading information to any insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA: A 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 is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

INDIANA: Any person who knowingly, and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

KENTUCKY: 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.

MAINE, TENNESSEE, VIRGINIA and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any Person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in NH Rev. Stat. Ann. § 638.20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application of 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 subjects such person to criminal and civil penalties.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (\$5,000) dollars and not more than ten thousand (\$10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are [sic] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For assistance, please call
Customer Service at
800-221-2554

CLAIMANT'S STATEMENT

Please Attach a Certified Death Certificate

Please show all names the deceased was known by, including full name, maiden name, hyphenated name, nickname, derivative form of first and/or middle name, or any alias.

1. Deceased's Name in Full:

2. Policy Numbers: _____

3. Deceased's Birth Date: _____ Source from which Birth Date Obtained: _____
Birth Certificate, Family Record, Other Record

4. Residence of Deceased at Death: _____
Street Address City State ZIP

5. Date of Death: _____ Place of Death: _____

6. Cause of Death _____ 7. Your relationship to the Deceased: _____

8. Employer of Deceased _____ Deceased's Occupation: _____

9. Is claim being made for Accidental Death Benefits? Yes No

10. If deceased has insurance with other companies, list names of companies and amounts below:

Names of Companies	Amounts

11. Marital Status of Deceased: _____ Spouse's Name: _____

Children of Deceased _____ Spouse's Address: _____

The furnishing of this form or its acceptance by the Company must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

The Claimant Information on the next page *must* be filled out completely in order to avoid any delay.

CLAIMANT INFORMATION

The information in this section pertains to the Claimant (the beneficiary)

Please read carefully. Please print or type and complete in full. This form must be signed and notarized.

1. Claimant's Full Name: _____

2. Date of Birth: _____ Social Security No. or Tax ID: _____
· Individual – Claimant's Social Security Number · Estate Tax ID Number
· Guardian – Child's Social Security Number · Trust Tax ID Number

3. Permanent Address: _____
Number, Street and Apt. or Suite No. (do not use a P.O. or in-care-of address)

City State Zip Code

4. Mailing Address: _____
(if different from above) Number, Street and Apt. or Suite No.

City State Zip Code

5. Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Please select your method of payment by marking the appropriate box below:

Check Settlement Option # _____ (refer to the policy and Claim instructions)

Please be sure to review the payment method information found in the Claim Instructions on page 1.

Under the penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number; and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report interest or dividends, or (c) that the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. person (including a U.S. resident alien).

Certification Instructions:

- You must cross out item 2 if the IRS has notified you that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.
- Read the Claim Fraud Warning issued by the laws of your state of residence located on page 2.

I certify that all answers on this form are correct and true, and I am aware of the law of my state concerning Claim Fraud.

Signature of Claimant: X _____
(See "Important Reminders" on Page 1, "Claim Instructions")

Subscribed and sworn to before me this _____ Day of _____, 20_____

Signature of Notary Public: X _____

Authorization

IMPORTANT: To avoid delay, please sign authorization below.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION

By my signature below: (1) I authorize National Benefit Life Insurance Company, its affiliates, reinsurers, and authorized representatives, including agents, insurance support organizations and service providers to receive all health information on the deceased individual named below; (2) I acknowledge that health information may include any and all individually identifiable health information within the past 20 years, including medical records, reports, prescription histories, diagnostic testing, and lab work on the diagnosis, treatment, and prognosis of any physical or mental condition and the use of drugs or alcohol, autopsy and toxicology reports, any employment or wage or financial information, phone call records, information about driving records (MVR), and information with respect to other insurance coverage or claims of the insured or family members for which claim is being made; (3) I authorize any licensed physician, medical practitioner, hospital, clinic, Medical Examiner, Coroner, or other medical care institution or medical related facility, pharmacy, pharmacy benefit manager, employer, insurance or reinsurance company, group policyholder, governmental or law enforcement agencies, Social Security Administration, the Veterans Administration, and the Department of Motor Vehicles, Kaiser Permanente, or other entity or person to disclose all health information on the deceased individual named below; (4) I understand that the information released under this Authorization will be used for the purposes of evaluating and administering a claim for benefits; (5) I acknowledge that this Authorization expires thirty (30) months from the date it is signed; (6) I understand that I can revoke this authorization at any time by giving written notice to the Insurance Company named above at the address shown above. I also understand that my revocation will not apply retroactively or prevent the Company from contesting a claim for insurance benefits; (7) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure claim review; however, the Company may not be able to make any benefit payments; (8) I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality; and (9) I agree that a photographic copy of this Authorization shall be as valid as the original and I may receive a copy of this Authorization after it is signed.

Signed this _____ day of _____, 20_____

X _____
 Signature of Next of Kin Relationship to Insured

Address: _____

_____ City State Zip Code

Phone Number: (____) _____

_____ Print Name of Deceased Insured

_____ Deceased Insured's Date of Birth

_____ Deceased Insured's Social Security Number