Life Insurance Claim Form

P.O. Box 5005, Batavia, IL 60510-5005
Phone: 866-863-9753 | Fax: 402-479-0146

POLICY NUMBER	

DECEDANT'S PERSONAL INFORMATION			
NAME IN FULL (First, Middle, Last)			
ADDRESS OF RESIDENCE (Street, City, State, Zip Code)			
OCCUPATION			
DATE OF BIRTH (MM/DD/YYYY)		PLACE OF BIRTH (City, State)	
DATE OF DEATH (MM/DD/YYYY)		PLACE OF DEATH (City, State)	
CAUSE OF DEATH			

These statements are true and complete. I understand that the furnishing of forms by the Company does not constitute an admission that there is any insurance in force.

Dated at _____ this _____ day of _____.
CITY AND STATE

Signed or acknowledged in the presence of:

_____
NON-RELATIVE WITNESS (PLEASE PRINT)

_____
SIGNATURE OF WITNESS

_____
ADDRESS OF WITNESS

_____
CITY, STATE, ZIP CODE

_____
CLAIMANT (PLEASE PRINT)

_____
SIGNATURE OF CLAIMANT

_____
ADDRESS OF CLAIMANT

_____
CITY, STATE, ZIP CODE

_____
CLAIMANTS SOCIAL SECURITY NUMBER

_____
CLAIMANT'S DATE OF BIRTH

_____
CLAIMANT'S PHONE NUMBER

_____
CLAIMANT'S EMAIL