



CLAIMANT'S STATEMENT
To be completed by each beneficiary
United Home Life Insurance/United Farm
Family Life Insurance
PO Box 7192, Indianapolis IN 46207-7192



The Company does not waive any right nor admit any claim by furnishing this blank form.

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

I, the claimant, hereby request settlement of Policy# _____ as follows:

- Lump Sum (cash)
- Transfer to new policy (attach copy of the application)
- Transfer to Supplementary Contract (attach copy of form 200-293)
- Transfer to existing policy # _____
- Other, please explain _____
- Pay Funeral Home \$ _____ Payee Name _____
(attach a copy of the assignment and itemized bill for payment)

In accordance with the provisions of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982:

- I DO NOT** want Federal Income Tax withheld from my distribution.
If you elect not to have Federal Income Tax withheld, you are responsible for payment of any tax due on the taxable portion of your distribution. You may also be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate. Such distribution is taxable in the year payment is issued.
- I DO** want Federal Income Tax withheld according to the applicable withholding provisions of the Tax Equity and Fiscal Responsibility Act of 1982.

Are any bankruptcy proceedings pending against the deceased or you as the beneficiary? Yes No If yes, explain:

Are you a US Citizen or Resident Alien? Yes No
If No: What is your immigration status/type of visa? _____
Please submit IRS form W-8 Ben if applicable.

TO WHOM IT MAY CONCERN: Please furnish to United Home Life Insurance/United Farm Family Life Insurance a copy of your reports or records for our insured _____ who died on _____, _____.
Month Day Year

I, the claimant, hereby certify under penalties of perjury, that the Social Security Number provided is true, correct, and complete.

Print name/address of Claimant.

DO NOT SIGN A BLANK FORM

| | |
|---------------|-----------------------------------|
| Name _____ | _____ |
| | Signature of Claimant |
| Address _____ | _____ |
| | Claimant's Social Security Number |
| _____ | _____ |
| | Claimant's Date of Birth |

State of _____ County of _____

On this _____ day of _____, _____, personally appeared before me the above named claimant, of full legal age, who subscribed the foregoing statement before me and made oath that the answers are each and all complete and true.

My county of residence is _____

(SEAL)

My commission expires _____

Notary Public

INSTRUCTIONS

(Any costs for documentation/reports shall be at the beneficiary's expense.)

1. **THIS STATEMENT MUST BE ACCOMPANIED WITH AN ORIGINAL OR CERTIFIED DEATH CERTIFICATE. (THE CERTIFICATE MUST INCLUDE: CAUSE OF DEATH, SOCIAL SECURITY NUMBER AND DATE OF BIRTH).**

2. If deceased purchased any policies on other persons and was the owner, these need to be included in the deceased's estate. Please notify us of this so we can update present ownership condition. **Be sure to inform us now to avoid future problems.**

3. **MEDICAL INFORMATION**

This information must be completed if the policy, or any insurance rider attached to any policy, is still in the contestable period (two years following the issue or reinstatement date). Otherwise, leave this section blank.

List the name and address of the deceased's primary care physician (family doctor). Also, list any other physicians, hospitals, or medical centers that treated the deceased in the past five years:

| <u>Physician</u> | <u>Address</u> | <u>City, State</u> | <u>Zip Code</u> |
|------------------|----------------|--------------------|-----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

(LIST ANY ADDITIONAL DOCTORS, HOSPITALS OR MEDICAL CENTERS ON SEPARATE SHEET OF PAPER)

4. **OTHER INFORMATION THAT MAY BE REQUIRED BY HOME OFFICE.**

In addition to this form some claims can require other reports/items. Most often, it will be something asked for by the Home Office after this claim form is received. Although the following is not all inclusive, it provides some information as to what could be requested.

- a. If death is other than natural, we will require a police/accident report, autopsy and toxicology report.
- b. If the beneficiary is under the age of 18 or declared incompetent, a copy of the court approved guardianship papers in which case the guardian would sign the claimant statement on behalf of the beneficiary.
- c. If the benefit is payable to an Estate and someone has been appointed by the court to handle the affairs of the decedent, a copy of "letter of administration" or "order appointing personal representative" in which case the claimant statement is signed by the appointed representative.
- d. Hospital, doctor and/or coroner reports. These reports are required when a claim is filed in the policy's contestable period (two years following issue or reinstatement date).