PROOFS OF DEATH-CLAIMANT'S STATEMENT

INSURING COMPANY:

☐ **American-Amicable Life Insurance Company of Texas**
P.O. Box 2549
Waco, TX 76702-2549
1-800-736-7311
E-mail: Claims@American-Amicable.com

☐ **Pioneer American Insurance Company**
P.O. Box 240
Waco, TX 76703-0240
1-800-736-7311
E-mail: Claims@PioneerAmericanInsurance.com

☐ **Pioneer Security Life Insurance Company**
P.O. Box 2550
Waco, TX 76702-2550
1-800-736-7311
E-mail: Claims@PioneerSecurityLife.com

☐ **Occidental Life Insurance Company of North Carolina**
P.O. Box 2595
Waco, TX 76702-2595
1-800-736-7311
E-mail: Claims@OccidentalLife.com

☐ **Peninsular Life Insurance Company**
P.O. Box 2523
Waco, TX 76702-2523
1-800-736-7311

Before making out this statement, read the instructions on the back of this form.

By furnishing forms and investigating the claim, the company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

1. Policy Numbers:_____ Amounts:_____
2. Deceased's name in full:_____ Marital Status:_____
3. Residence at death: Number:_____ Street:_____ City:_____ State:_____
4. Usual Occupation (not just Retired):_____
5. a. Date of deceased's birth:_____ b. Place of birth:_____
6. a. Date of death:_____ b. Place of death:_____
   c. Cause of death:_____

Note: Complete questions 7 through 11 only if policy has been in force less than 2 years and / or accidental benefits are claimed.

7. Date deceased first complained of, or gave other indications of his / her last illness:_____
8. When did deceased first consult a physician for his / her last illness?_____
9. On what date did deceased last attend to his / her usual work?_____
10. Give names and address of all physicians who attended deceased during his / her last illness and during the five years prior thereto:

Names	Addresses	Date of Attendance	Disease or Condition

11. In what other companies, and for what amounts, was the life of the deceased insured under accident and / or life policies?

12. I hereby certify that the policy of insurance for the listed policy has been ☐ ENCLOSED ☐ LOST ☐ DESTROYED
13. Taxpayer I.D. Information:

Enter the claimant's taxpayer identification number in the appropriate box. For most individuals this is your social security number.	CLAIMANT'S S.S. NO.	OR	TAX I.D. NO.

Note: If the account is in more than one name, see the chart on reverse side for guidelines on which number to give the payer. If the Social Security number or Tax I.D. number is not provided, and backup withholding is applicable, taxes will be withheld from the proceeds.

CERTIFICATION - Under penalties of perjury I certify that
(1) The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me) and
(2) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report at interest or dividends or the IRS has notified me that I am no longer subject to backup withholding.

	CLAIMANT'S SIGNATURE	DATE
[redacted]		

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.

The undersigned agrees that the written statements of all physicians who attended or treated the insured and all other papers called for by the company shall constitute and they are hereby made a part of these proofs of death, and further agrees that all provisions of law forbidding any physician or other person who attended deceased from disclosing any knowledge or information acquired by him are hereby waived and such physician or other person is hereby authorized to make such disclosures. A photostatic copy of this agreement shall be as valid as the original.

14. Dated at_____ this_____ day of_____, 20_____.
    City & State
15. Claimant's Signature_____ Date of Birth_____ Relationship_____
16. Claimant's Address_____
    Street Address or Box No.
    _____ Daytime Phone No._____
    City State ZIP
17. Witness to Signature_____
    (Does not need to be notarized)

"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."

GENERAL INSTRUCTIONS

1. **Claimant's Statement.** This statement must be completed by the beneficiary. If there is more than one beneficiary, each must complete a separate statement.
2. **Death Certificate.** A Certified copy of the death certificate is to be furnished with this form.
3. **Newspaper Account.** When available, a newspaper account of the death should be submitted.
4. **Policy.** The policy should be sent with this Statement. Explain if not enclosed.

SPECIAL INSTRUCTIONS

Estate Beneficiary. The Statement must be completed by the Executor or Administrator, and a certified copy of appointment must be furnished.

Minor Beneficiary. The Statement is to be completed by the legally appointed guardian of the Estate of the minor and an official certificate of the guardian's appointment must be furnished.

Predeceased Beneficiary. When a beneficiary has predeceased the insured, a certified copy of the death certificate is to be furnished.

Class Beneficiaries. (Example: "Children of the Insured") An affidavit showing the names and dates of birth of each must be submitted, or submit a copy of an Obituary or copy of Will listing all persons in the designated class.

Assignee. The Statement is to be completed by the assignee. If the assignment is no longer effective, a release of assignment from the assignee should be submitted. If collaterally assigned, the statement should be completed by both the beneficiary and assignee and the amount claimed by the assignee indicated on the statement.

Guidelines for Determining the Proper Identification Number to Give the Payer.—Social Security numbers have nine digits separated by two hyphens: i.e., 000-00-0000. Employer identification numbers have nine digits separated by only one hyphen: I.E., 00-0000000. The table below will help you determine the number to give the payer.

For this type of account:	Give the SOCIAL SECURITY number of—	For this type of Account	Give the TAX IDENTIFICATION number of—
1. An individual's account	The individual	8. Sole proprietorship account	The owner
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, any one of the individuals	9. A valid trust, estate, or pension trust	Legal entity (Do not furnish the identifying number of the personal representative or trustee unless the legal entity itself is not designated in the account title.)
3. Husband and wife (joint account)	The actual owner of the account or, if joint funds, either person	10. Corporate account	The corporation
4. Custodian account of a minor (Uniform Gift to Minors Act)	The Minor	11. Religious, charitable, or educational organization account	The organization
5. Adult and minor (joint account)	The adult or, if the minor is the only contributor, the minor	12. Partnership account held in the name of the business	The partnership
6. Account in the name of guardian or committee for a designated ward, minor, or incompetent person	The ward, minor, or incompetent person	13. Association, club, or other tax-exempt organization	The organization
7. a. The usual revocable savings trust account (grantor is also trustee)	The grantor-trustee	14. A broker or registered nominee	The broker or nominee
b. So-called trust account that is not legal or valid trust under State law	The actual owner	15. Account in the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity