SENIOR LIFE
INSURANCE COMPANY

Senior Life Insurance Company
P.O. Box 2447
Thomasville, GA 31799-2447
1-877-777-8808
A Georgia Stock Company • Executive Offices: Thomasville, Georgia

Claims Form

AUTHORIZATION – MEDICAL INFORMATION FOR FILING A DEATH CLAIM

"I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility or insurance company that has any records or knowledge of the deceased or the deceased's health to give to the Claims Department of Senior Life Insurance Company or its reinsurers any such information including mental, alcohol, drug or HIV (Human Immunodeficiency Virus) related information for the purpose of assessing the pending claim. This authorization may be used for the duration of this claim. I may request and receive a copy of any medical information obtained with this authorization. I am entitled to receive a copy of this authorization. My Authorized Representative is also entltled to receive a copy of this authorization form. A photostatic copy of this authorization shall be as valid as the original. I declare that I am of legal age to file this claim."

Name of Deceased _____

Policy # _____

Relationship to Deceased _____

Next of Kin (print name) _____

Street Address _____

City _____ State _____ Zip _____

If death has occurred within 2 years of issue/reinstatement date or if the death was by Accidental means, list the doctors/hospitals that treated the insured in the **5 years prior to the application date.**

Primary Doctor _____
Address _____
City _____ St. _____ Zip _____
Phone ( ) _____

Doctor _____
Address _____
City _____ St. _____ Zip _____
Phone ( ) _____

Hospital _____
Address _____
City _____ St. _____ Zip _____
Phone ( ) _____

Clinic _____
Address _____
City _____ St. _____ Zip _____
Phone ( ) _____

Dated this _____ day of _____ , _____

X _____
Signature of Next of Kin

PLEASE COMPLETE THE APPROPRIATE INFORMATION ON REVERSE SIDE OF THIS FORM.

BENEFICIARY INFORMATION

Name of Beneficiary _____ Relationship _____

Address _____ City _____ St. ___ Zip _____

Social Security # _____ Phone # ( ) _____ Date of Birth _____

Name of Beneficiary _____ Relationship _____

Address _____ City _____ St. ___ Zip _____

Social Security # _____ Phone # ( ) _____ Date of Birth _____

ASSIGNMENT OF PROCEEDS OF INSURANCE

I, _____ (Beneficiary), being entitled to receive benefits under Policy # _____ issued by Senior Life Insurance Company on the life of _____ (Deceased/Insured) now deceased, and having contracted with and being indebted to _____ (Funeral Home) of _____ (Address, City, State, Zip) for funeral services and merchandise for the deceased, do hereby set over, assign and transfer unto said Funeral Director the sum of _____ Dollars ($ _____) out of the proceeds of said Insurance Policy; and I hereby authorize and direct Senior Life Insurance Company to make its check payable to said Funeral Director for the assigned amount and to pay the remainder of the proceeds of said Insurance Policy, if any, to me.

_____ (Beneficiary Signature) _____ (Beneficiary Signature)

NOTARY SEAL

Sworn and subscribed before me the _____ day of _____ , _____

NOTARY PUBLIC _____ My commission expires _____

AFFIDAVIT FOR LOST POLICY

I, the undersigned, hereby certify that Policy # _____ issued on the life of _____ by Senior Life Insurance Company has been lost or destroyed.

Beneficiary Signature _____ Date _____

BENEFICIARY CERTIFICATION

Checklist:

❒ Certified Death Certificate ❒ Original Policy/Affidavit for Lost Policy ❒ Claim Form CL3209 ❒ HIPAA10

By signing below I, the Beneficiary, certify that the statements in this form are true to the best of my knowledge and that all necessary paperwork has been completed according to the above checklist.

Beneficiary Signature _____ Date _____

Beneficiary Signature _____ Date _____