ASSURED LIFE ASSOCIATION
PO Box 3169
Englewood, CO 80155
303-792-9777 or 800-777-9777

INSTRUCTIONS FOR FILING A DEATH CLAIM

1. A Certified copy of the Certificate of Death of the insured is required (a photocopy is not sufficient for our files).
2. Return the original Insurance Certificate, or complete and return a Lost Certificate Affidavit.
3. A Claimant's Statement must be completed by the primary beneficiary (ies). If all the primary beneficiaries have pre-deceased the Insured, the Contingent beneficiary (ies) must then complete this Claimant Statement.
4. If a certificate is payable to a named beneficiary or beneficiaries, and the beneficiary is deceased, a copy of the death certificate of any such beneficiary who is now deceased must be furnished
5. In the event of multiple beneficiaries, each beneficiary must complete a claimant statement and furnish their Social Security Number.
6. If a certificate is payable to the Estate of the Insured, this Statement must be completed by the Executor, Administrator, or Personal Representative of the Estate. A legal copy of the Executor's, Administrator's, or Personal Representative's appointment must be furnished.
7. If the certificate is payable to a minor, this Statement must be completed by his or her legally appointed guardian, and a copy of the guardian's appointment and qualification must be furnished. If the surviving parent is the guardian, a copy of the birth certificate of the child must be furnished.
8. If a certificate, or any part of it, is payable to "children" or others of a "class", a sworn statement must be furnished stating the names and dates of birth of each member of the class. If any member of a class has died, a certified copy of the death certificate must be furnished, and the statement must indicate whether they died unmarried, in testate, and without issue. Every question must be answered in full.
9. If a certificate has a collateral assignment, a certified statement (assignment form) documenting the amount of outstanding balance for which the certificate was assigned must be furnished to the Society by the Assignee.
   A Claimant's Statement or W-9 Form must be completed by the Assignee.

IMPORTANT TAX INFORMATION

You (as a Payee) are required by law to provide us (as Payor) with your correct taxpayer identification number. Accounts that have a missing or incorrect Taxpayer Identification Number will be subject to backup withholding at a 20% rate on interest, dividends and other payments beginning January 1, 1984. If you have not provided us with your correct Taxpayer Identification number, you may be subject to a $50 penalty imposed by the Internal Revenue Service. Backup withholding is different from the 10% withholding and dividends that was replaced in 1983. Backup withholding is not an additional tax. Rather, the tax liability of persons subject to backup withholding will be reduced by the amount of tax withheld. If withholding results in an overpayment of taxes, a refund may be obtained.

IMPORTANT FRAUD INFORMATION

***For California Residents Only*:** "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 a state prison.

***For Colorado Residents Only*:** "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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance with the Department of Regulatory Agencies."

For Florida Residents Only: "Any 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."

For Kentucky Residents Only: "Any Person Who Knowingly and with Intent to Defraud Any Insurance Company or Other Person Files an Application for Insurance (Or 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."

For Maine and Tennessee Residents Only: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and/or a denial of insurance benefits."

For New Jersey Residents Only: "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

For New Mexico Residents Only: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties."

For New York Residents Only: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

For Ohio Residents Only: "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."

For Oregon Residents Only: "Any person who knowingly and with intent to defraud, submits an application to or files a claim with an insurer containing materially false, incomplete, misleading or deceptive facts, statements or information may be guilty of insurance fraud which is a crime and could subject such person to civil and criminal penalties which may include fines and confinement in prison."

For Pennsylvania Residents Only: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for 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."

For West Virginia Residents Only: "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."

For Washington Residents Only: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All Other State Residents except Virginia: "Any person who, with intent to defraud or knowingly, submits an application to or files a claim with an insurer containing false, incomplete, misleading or deceptive facts, statements or information is guilty of insurance fraud which is a crime and subjects such person to civil and criminal penalties which may include fines and confinement in prison."

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CLAIMANT'S STATEMENT

PLEASE READ THE ENCLOSED FILING INSTRUCTIONS AND FRAUD INFORMATION.

Certificate #: _____ Claim No. _____(provided by Home Office)

A. **INFORMATION ABOUT THE DECEDENT**

1. Name of deceased insured _____2. Date of birth _____
3. Residence at death _____
4. Date of death _____ 5. Cause of death _____
6. Place of death _____
7. If death was due to accident state: (a) Date of accident _____
   (b) Place of accident _____
   (c) How accident occurred _____

B. COMPLETE THIS SECTION ONLY IF DEATH OCCURRED WITHIN TWO YEARS FROM DATE OF ISSUE OR REINSTATEMENT OF THE INSURANCE POLICY:

1. List names and addresses of all doctors and hospitals that treated the deceased within the last five years.

Name	Address/Phone #	Dates	Condition(s)

2. Date deceased last worked at his/her regular occupation? _____
3. Date deceased first consulted a physician for his/her final illness? _____
4. Did the deceased ever smoke cigarettes? ☐ Yes ☐ No If yes, list exact dates smoked _____
5. List all other insurance on life of deceased:

Company	Certificate No(s). & Amount(s)	Policy issue date(s)

C. INFORMATION ABOUT THE CLAIMANT

1. Your name _____
2. Mailing address _____
   Street City State Zip
3. Your Social Security or Tax Identification No. _____
(Under penalties of perjury, I certify that the number shown on this form is the correct taxpayer I.D. number of the claimant.)

4. Your date of birth _____ 5. Your relationship to the deceased _____
6. Your telephone number: (Home) _____ (Work) _____
7. If there is a taxable gain on this claim do you want Federal Withholding? _____YES _____NO

The undersigned agrees that the Company does not recognize the validity of this claim or waive any of its rights or defenses by furnishing this or any other form or by investigating this claim. I certify that the statements above are true and correct to the best of my knowledge and the named deceased is the person insured under the above certificate(s).

Date: _____ Claimant's Signature X _____

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LOST INSURANCE CERTIFICATE AFFIDAVIT FOR CLAIM PROCEEDS

I, _____, declare that I am of legal age and the beneficiary of the insurance certificate number _____, issued by Assured Life Association on _____.

(Name of Insured)

I further declare that I am unable at this time to deliver to the Association the insurance certificate for the reason that it is not in my possession or subject to my control. I further declare that should the insurance certificate hereafter come into my possession or subject to my control or direction I will at once forward or cause the same to be forwarded to the Home office of the Association.

_____ _____

(DATE) (SIGNATURE)

****

_____(PRINT YOUR NAME)

_____(YOUR STREET ADDRESS)

_____(CITY, STATE, ZIP)