

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 WARNING

Arizona Residents: "For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

California Residents: "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."

Colorado Residents: "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 within the Department of Regulatory Agencies."

Delaware, Idaho, Indiana, Oklahoma Residents: "**WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a **statement** of claim containing any false, incomplete or misleading information is guilty of a felony."

Florida Residents: "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."

Kentucky Residents: “Any person who knowingly and with intent to defraud any insurance company or other person files 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.”

Louisiana Residents: “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.”

Maine and Tennessee Residents: “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.”

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

New Mexico Residents: “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 civil fines and criminal penalties.”

New York Residents: “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.”

Ohio Residents: “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.”

Pennsylvania Residents: “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.”

Puerto Rico Residents: “Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.”

Virginia and Washington Residents: “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: “Any person who knowingly, and/or 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 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. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant”

ASSURED LIFE ASSOCIATION
PO BOX 3169
ENGLEWOOD, CO 80155-3169
303-792-9777 OR 800-777-9777

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. 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 _____

The foregoing document was acknowledged, subscribed and sworn to before me on

_____ in _____
(date) (city, state)

WITNESS my hand and official seal.

(SEAL)

Notary Public: _____

My commission expires: _____

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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 «Field18», issued by Assured Life Association on «Field17».

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)

Direct Deposit lets you receive your payment in a more convenient way: Avoid trips to the bank and receive the funds faster.

AUTHORIZATION AGREEMENT FOR AUTOMATED DEPOSITS (CREDITS)

Certificate Number: _____

AGREEMENT:

I (we), _____ hereby authorize Assured Life Association to initiate credit entries to the account indicated below with the depository named below (hereinafter referred to as "BANK"). The authority to initiate entries shall include the authority to initiate debit entries and adjustments to any credit entries, for the purpose of correcting any error in the initiation or processing of credit entries pursuant to this authority. The authority herein granted shall remain in full force and affect until Assured Life Association has received written notice from one of the undersigned of termination. The termination of authority shall take effect within such time as the BANK has a reasonable opportunity to act pursuant to the termination.

I hereby authorize the Company named above to initiate credits to my _____ Checking or my _____ Savings account with the Financial Institution indicated below:

Bank Name: _____

Address: _____

City State Zip: _____

Account Routing Number _____ Account Number _____

Account Owner's Name(s): _____

Signature of Account Holder(s): _____

_____ Date

PLEASE ENCLOSE A VOIDED CHECK OR SAVINGS ACCOUNT DEPOSIT SLIP