



# Death Benefits Claim Form

(CLAIM FORM MUST BE RETURNED WITH AN ORIGINAL CERTIFIED DEATH CERTIFICATE)

## SECTION I

Full Name of Deceased \_\_\_\_\_ Policy Number(s) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Residence Address of Deceased \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date of Death \_\_\_\_\_ Place of Death \_\_\_\_\_ Cause of Death \_\_\_\_\_

## SECTION II

Occupation of Deceased \_\_\_\_\_ Date Last Worked \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

When did deceased first complain or give other indications of last illness? \_\_\_\_\_

Name/Addresses or phone numbers of all physicians or practitioners that insured consulted: \_\_\_\_\_

Name	Address	Phone Number	Date of Attendance	Disease/Condition
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

## SECTION III

The statements above are true and complete. I/we agree that the Company may rely upon them as part of the proofs of death under the policies numbered above. Any physician or practitioner who has attended, Deceased Insured, and/or any hospital (including Veterans Administration Hospital) or other institution in which the Deceased Insured was treated or confined, is hereby authorized to furnish to Leaders Life Insurance Company or its representatives, any and all information and records with respect to any illness or injury, medical history, consultations, prescriptions or treatments pertaining to the Deceased Insured. Such information may be included as part of the proofs of death submitted to the Company. I further understand that the information authorized for release may indicate the presence of a communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

**WARNING:** Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Applicable to OK residents: **WARNING:** Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Applicable to AR and LA 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.

Applicable to KS residents: Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information may be guilty of insurance fraud as determined by a court of law.

Applicable to AL residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Applicable to FL 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.

Applicable to NM 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.

Applicable to TX residents: 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 state prison.

Print Name of Beneficiary \_\_\_\_\_ Signature of Beneficiary \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Residence Address of Beneficiary \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

\_\_\_\_\_ Date at \_\_\_\_\_ This \_\_\_\_\_ Day of \_\_\_\_\_

Phone Number \_\_\_\_\_ (City & State) \_\_\_\_\_ (Day) \_\_\_\_\_ (Month & Year)

If claim is compensable, pay by:  Check  Bank Deposit (Please complete attached Direct Deposit Form.)

**\*\*NOTARY\*\***

State of \_\_\_\_\_, County of \_\_\_\_\_ On this \_\_\_\_\_ day of \_\_\_\_\_ personally appeared before me the above named \_\_\_\_\_ who is know to me and who subscribed the foregoing statement before me and made Oath that the foregoing answers are each and all complete.

Notary Signature \_\_\_\_\_ My Commission Expires \_\_\_\_\_

SEAL