AMERICAN FIDELITY
a different opinion

Death Benefit Claim Filing Instructions

TO HELP AVOID DELAY, PLEASE READ THESE INSTRUCTIONS CAREFULLY AND COMPLETE STATEMENT OF CLAIMANT.

- Submit a **CERTIFIED** Death Certificate of the deceased insured or annuitant showing the Cause and Manner of Death.
- Submit a copy of the **CERTIFIED** Death Certificate of each deceased beneficiary.
- Submit a completed **STATEMENT OF CLAIMANT form**. Complete only the highlighted sections. Each beneficiary must complete and sign a Statement of Claimant.

Claims by an Estate – The Executor (Administrator or Personal Representative) of the Estate must sign all documents including Statement of Claimant. A certified copy of the appointment papers should be included. A Last Will and Testament cannot be accepted as proof of authority of executorship.

Assignments – If all or any portion of the benefits have been assigned to a funeral home or any other entity, please include a copy of that assignment signed by each beneficiary.

If the beneficiary is a minor – A legal guardian must be appointed by a court giving custody over the minor's property and estate. The legal guardian should sign the claimant statement and include a copy of the court appointed guardianship papers.

If any beneficiary has designated an attorney-in-fact – The attorney(s)-in-fact should sign on behalf of the beneficiary, and include a copy of the Power of Attorney appointment.

If the policy is less than two years old – As part of our normal process, additional information and documentation will be required with the claim. An **AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION** form must be completed and submitted with the claim.

Claim Form Fraud Statements

The following fraud language is attached to, and made part of, this claim form. **Please read and do not remove this page from this claim form.**

If you live in a jurisdiction not mentioned below, the following applies to you: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

Alabama - 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.

Alaska - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona - 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.

Arkansas, District of Columbia, Louisiana, Rhode Island and West Virginia - 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.

California and Texas - For your protection California and Texas law requires the following to appear on this form: Any person who knowingly presents 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.

Colorado - 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 and Oklahoma - 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.

Florida - 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.

Indiana - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky - 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.

Maine, Tennessee, Virginia and Washington - 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 or a denial of insurance benefits.

Maryland - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire - Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

New Mexico - 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.

Ohio - 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 - 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 - 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.

Life & Annuity - Worksite
P.O. Box 25160
Oklahoma City, Ok. 73125-0160
Toll Free Phone 1-800-662-1113
Toll Free Fax 1-800-818-3453
americanfidelity.com

STATEMENT OF CLAIMANT

TO BE COMPLETED FOR LIFE AND/OR ANNUITY BENEFITS

In furnishing this form, the Company reserves all of its rights under the Policy and waives none of the conditions of the Policy.

INSURED'S IDENTIFICATION

Policy No. _____

Insured's Full Name _____ Social Security # _____

Address _____ City _____ State _____ Zip: _____

Date of Birth _____ Date of Death _____ Cause of Death: _____

DEPENDENT IDENTIFICATION (If claim is on a dependent)

Name of Deceased _____ Relationship to Insured: _____

Address _____ City _____ State _____ Zip: _____

Date of Birth _____ Social Security # _____ Date of Death: _____

CLAIMANT'S IDENTIFICATION

Your Name _____ Relationship to Deceased _____

Social Security # _____ Telephone # _____ Date of Birth _____

Address _____ City _____ State _____ Zip: _____

Email _____

Do you claim this insurance as: ❑ Beneficiary/Heir ❑ Executor/Administrator ❑ Guardian ❑ Power of Attorney

MEDICAL INFORMATION – NEED MEDICAL HISTORY FOR: _____

Date Insured first consulted a physician for last illness: _____

Name and addresses of all physicians who treated the deceased and of all hospitals or institutions where the insured was treated during the last five years: (Attach additional pages if needed)

Name of Physician or Hospital	Address	Dates Treated	Type of Illness

ACCIDENTS (Complete only if loss is the result of accidental injury)

Where did the accident happen? _____ Date of Accident _____

How did the accident happen? _____

If the policy contains an accidental death benefit and claim is being made for it, please furnish a detailed police report, coroner's report and newspaper clippings (if applicable). We may require other information depending on the circumstances of the death.

CERTIFICATION

I certify the above statements are true and complete to the best of my knowledge.

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 may be guilty of insurance fraud and subject to criminal and civil penalties. Refer to "**Fraud Warning Notices**" for your state.

Signed _____ Date: _____

(Claimant/Beneficiary)

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about the deceased's health including the deceased's entire medical record and history of treatment for physical and/or emotional illness (to include psychological testing, except psychotherapy notes) to individuals representing American Fidelity Assurance Company (AFA) who are involved in determining whether the deceased is eligible for benefits under this insurance coverage. Specified entities include: licensed physicians or medical practitioners; hospitals, clinics or medically-related facilities; health plans; Veteran's Administration; or other government healthcare payors or providers; past or present employers; pharmacies; insurance companies; the Social Security Administration; retirement systems; Department of Motor Vehicles, and Workers' Compensation Carriers.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which the deceased may have been treated. This authorization excludes disclosure of the result of a test for HIV if the deceased had tested HIV positive but had not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the deceased had AIDS.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or a delay of benefits. I understand that I may revoke this authorization at any time by writing to AFA, PO Box 25160, Oklahoma City, OK 73125-0160 or by calling, toll-free, 1-800-662-1113. I understand that my right to revoke this authorization is limited to the extent that: AFA has taken action in reliance on this authorization; or, the law provides AFA with the right to contest the deceased's insurance coverage or a claim under the deceased's insurance coverage. A copy of this authorization will be as valid as the original.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

This authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

Signature of Personal Representative/Beneficiary	Printed Name (Deceased)	Date of Birth (Deceased)
Relationship to Deceased	AFA Account#	Date

If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.

Please retain a copy for your personal records, or you may request a copy from our Company.