Clear Form

MOUNTAIN LIFE INSURANCE COMPANY

P. O. Box 240 - Alcoa, TN 37701 - (865) 970-2800 - (800) 888-6542

PROOF OF DEATH
CLAIMANT'S STATEMENT

Before completing this statement, please read the instructions on the reverse side.

NOTE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. (In Arkansas) 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.

PART ONE - To be completed in full

Name of Deceased (Print in full)		Policy Number(s)
Date and Place of Birth	Date and Place of Death	Cause of Death
Name of Beneficiary (Print in Full)	Date of Birth	Relationship to Deceased
Address (Street, City, State, Zip)		Telephone Number

THE POLICY AND A CERTIFIED COPY OF THE DEATH CERTIFICATE MUST ACCOMPANY THIS CLAIM FORM. If the policy is lost, has been misplaced or inadvertently destroyed please indicate: _____

Method of Settlement ☐ Lump Sum ☐ Settlement Option - Specify (See reverse)

Beneficiary/Payee Signature (Required) X	Date	Social Security Number:

If Policy is assigned, name & address of Assignee: _____ _____	Amount of Assignee's claim _____
	Assignee's certification by: _____

PART TWO - To be completed only if: 1. Death has occurred within two years of original issue or reinstatement, or 2. Accidental death benefits are being claimed (Please furnish copy of accident/incident report.)

Date of accident or date deceased first complained of, or gave other indication of last illness.	Date deceased first consulted a physician for last illness.

Names and addresses of all physicians who attended to deceased and hospitals where treated during the past five years.

Name	Address (Street, City, State, Zip)	Dates	Disease or Condition

AUTHORIZATION

Name of Deceased	Your Relationship to Deceased

I hereby authorize any individual, physician, medical practitioner, hospital, clinic or other medical related facility, Medical Information Bureau, consumer reporting agency, rehabilitative assessment agency or government authority to furnish Mountain Life Insurance Company, its reinsurers or their representatives any information related to the health, medical history, diagnosis, and treatment (including copies of records) concerning the above referenced individual. These records should include any treatment regarding alcoholism, drug abuse, AIDS, HIV testing, AIDS related illness and psychiatric care or any physical or mental condition and/or treatment rendered.

This information is to be used for the purpose of determining insurance benefits. This authorization shall be valid for a period of one year from the date of signature.

I also authorize any employer, insurance company or insurance support organization to furnish information regarding benefits to which I may be entitled. I understand that I have a right to receive a copy of this authorization upon request. A Photocopy of this authorization shall be considered as valid as the original.

Signature of Next of Kin	Date
Address	Witness Signature

INSTRUCTIONS FOR COMPLETING PROOF OF DEATH

The furnishing of claim forms does not constitute an admission by this Company that there was any insurance in force at the time of death.

1. When the proceeds are payable to the Estate of the Insured, the claimant's statement must be completed by the Executor or Administrator, as the case may be. A certified copy of the Letters Testamentary or Letters of Administration must accompany this form.

2. When the proceeds of a policy are payable to a minor, the claimant's statement must be completed by the Legal Guardian of the child's estate. A certified copy of Letters of Guardianship must accompany this form. If no legal guardianship is established, the Proceeds will be held by the Company at interest, until age of majority.

3. When the proceeds of a policy are payable to a contingent beneficiary because of the prior death of the primary beneficiary, the contingent beneficiary is required to furnish a certificate of death covering the death of the primary beneficiary in addition to the other claim documents. This certificate may be obtained from public records.

4. When unnamed children (e.g., all surviving children) are designated as beneficiaries, the Company must be furnished with an affidavit giving the name, birth date and the residence address of all such children. The affidavit is to be made by a relative of the family having such information.

5. If there is more than one beneficiary, the names, birth dates and addresses of all other beneficiaries should be listed below.

Beneficiary (Signature Required)	Birth date	Telephone Social Security Number	Print Name and Address (Street, City, State, and Zip)
		[ ] - - -	
		[ ] - - -	
		[ ] - - -	
		[ ] - - -	
		[ ] - - -	

SETTLEMENT OPTIONS AVAILABLE

1. Lump sum (unless directed otherwise by the Insured).
2. Proceeds left on deposit at interest with right of withdrawal.
3. Installments of a specified amount ore for a specified length of time.
4. Installments providing a life income.

If one of these options is indicated on the reverse side of this form, full information will be furnished promptly.

MOUNTAIN LIFE INSURANCE COMPANY
P.O. Box 240
Alcoa, Tennessee 37701-0240
800-888-6542

Medical Records Release Authorization

Completion of this Authorization is required in order to consider your application for our insurance or to make a determination of eligibility for benefits on your claim.

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose my medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) to Mountain Life Insurance Company for the purpose of:

Circle the purpose(s)

1) **Determining eligibility for insurance;**

2) **Determining benefits payable on a disability claim;**

3) **Determining benefits payable on a life claim.**

I understand and agree that Mountain Life Insurance Company may disclose my medical records and the information contained in those records to third parties, such as insurance companies, or to the representatives of such third parties (including reinsurers and information agencies) for the purpose(s) stated above.

I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization, except to the extent that any health care provider or Mountain Life Insurance Company has acted in reliance upon this Authorization. My revocation of this Authorization must be submitted in writing to:

Mountain Life Insurance Company
P.O. Box 240
Alcoa, Tennessee 37701-0240

This Authorization will expire on _____, or if no date is filled in, twelve (12) months after the date the Authorization is signed.

A photocopy of the Authorization will be as valid as the original for the authorized purpose(s).

_____ _____
Signature of Individual Whose Information is to be Disclosed or Authorized Representative **Date of Birth**

_____ _____
Print Name of Individual **Date**