PROVIDENT AMERICAN
I N S U R A N C E

PROOF OF DEATH - BENEFICIARY'S STATEMENT

Failure to complete this form in its entirety may result in a delay in processing this claim

TO FILE A CLAIM, PLEASE SEND US:

1. Certified copy of the Death Certificate
2. The orginal policy or a completed "Lost Policy" affidavit
3. Assignment of Benefits to the funeral home, if benefits are to be assigned

UNDER THE FOLLOWING CIRCUMSTANCES, PLEASE SEND THE ADDITIONAL ITEMS LISTED:

- **If this is a Life Policy Less Than 2 Years Old -** Please send **Proof of Death - Physician's Statement -** This statement should be completed by the regular doctor of the deceased, not necessarily the doctor who attended the deceased at death.
- **If the Estate is the Beneficiary -** Please send us a copy of the court order appointment of the Administrator/Executor of the insured's Estate.
- **If a Minor is the Beneficiary -** Please send us a copy of the court order appointment of the legal guardian of the property and/or Estate of any minor child.
- **If the Beneficiary Has Died Prior to the Death of the Insured -** Please send us a copy of the certified death certificate of the beneficiary.
- **If the Death was Investigated by Any Law Enforcement Agency -** A copy of the police report, including the toxicology results

DECEDENT INFORMATION

LAST NAME FIRST NAME MIDDLE INITIAL MAIDEN NAME/ALIAS

ADDRESS CITY ST ZIP

SOCIAL SECURITY NUMBER BIRTH DATE POLICY NUMBER

OCCUPATION AT TIME OF DEATH DATE OF DEATH

PLACE OF DEATH CAUSE OF DEATH

If death was due to an accident, send us a copy of the police or coroner's report.
When was the accident? _______________ Please give us details of the accident:

If death was due to an illness, when did the deceased first complain of, or give indication of, this illness?
When did the deceased first consult a physician for this illness?

Complete this section only if the policy is two years old or less

Names and addresses of all physicians who attended deceased during his last illness and during the five years before death:

PHYSICIAN NAME ADDRESS DATES OF ATTENDANCE DISEASE/CONDITION

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The undersigned hereby applies to Provident American Insurance Company for payment of said insurance and agrees that the written statements and affidavits of all the physicians who attended or treated the insured, and all other papers called for by the instructions hereon, shall constitute and they are hereby made a part of these Proof of Death and further agrees that the furnishing of this form, or of any other forms supplemental thereto, shall not constitute nor be considered an admission by Provident American Insurance Company that there was any insurance in force on the life in question, nor a waiver of any of its rights or defenses.

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is subject to criminal and civil penalties.

BENEFICIARY/CLAIMANT'S SIGNATURE PRINT BENEFICIARY/CLAIMANT'S NAME SOCIAL SECURITY NUMBER BIRTHDATE

BENEFICIARY/CLAIMANT'S ADDRESS CITY ST PHONE NUMBER

WITNESSED BY

Signed at_______________________ this__________ day of_____________ 20 ______

CITY/STATE

Please review and sign the attached "Authorization to Obtain Information" form. Two copies are attached: return one copy to Provident American Insurance Company and keep one for your records. By returning the signed authorization with your claim, you will help us process your claim as quickly and efficiently as possible.

MAIL TO: PROVIDENT AMERICAN INSURANCE COMPANY
10501 NORTH CENTRAL EXPRESSWAY, SUITE 200, Dallas, TX 75231
PHONE: 800.933.9456 OR 214.696.9091 FAX: 214.237.8664