American Income Life Insurance Company

P.O. Box 2500 • Waco, Texas 76702

PROOFS OF DEATH — CLAIMANT'S STATEMENT

Please carefully read all of the following information before completing this statement.

Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Arkansas, Louisiana, Rhode Island, Texas 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.

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.

California: For your protection California law requires that you be made aware of the following: 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: 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.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly or 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.

Hawaii: For your protection, Hawaii law requires you to be informed that any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Indiana: Any 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 or 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: 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.

Minnesota: Any 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 of fraudulent claim for payment of a loss of 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.

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.

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

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.

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 include imprisonment, fines and denial of insurance benefits.

Proofs of Death Submitted to:

AMERICAN INCOME LIFE INSURANCE COMPANY

PO BOX 2500 • Waco, TX 76702
Phone (254) 761-6400 • Fax (254) 741-5705
Web www.ailife.com • Email CL@ailife.com

INSTRUCTIONS FOR SUBMITTING A LIFE CLAIM

1) Complete as Follows: Part A and C by the Beneficiary, Guardian or Personal Representative for all claims.
Part B by the Beneficiary - To be completed only if policy is less than 2 years old.
Part D by the Physician - To be completed only if policy is less than 2 years old.
Part E by the Beneficiary - Complete only fields with an asterisk* and sign and date at the bottom.
2) To expedite Payment, all questions must be answered fully and accurately.
3) Send this completed form, along with a Death Certificate (Certified Death Certificate required if face amount exceeds $15,000), and Obituary (if available) to one of the above.

Part A - To be Completed by Beneficiary

Policy Numbers			
Deceased's Name	Deceased's Date of Birth	Deceased's Gender ☐ Male ☐ Female	Deceased Union and Local # *(if Union member)*
Deceased's Address	Did Death Result From: ☐ Suicide ☐ Homicide ☐ Accident If yes, please include all Accident/Police Reports and Newspaper Articles		
Date of Death	Place of Death (if Hospital, Give Name)	Cause of Death	
Beneficiary's Name	Beneficiary's Relationship to Insured		
Beneficiary's Mailing Address	Beneficiary's Telephone Number		
	Beneficiary's Social Security Number		
Beneficiary's Email Address	Beneficiary's Date of Birth		

Part B - To be Completed by Beneficiary **COMPLETE ONLY IF POLICY IS LESS THAN 2 YEARS OLD**

Give the names and addresses of all physicians who treated the deceased during the 5 years prior to death:

Name	Address	Disease or Condition	Dates

When did deceased first complain, or give other indication of illness?	When did deceased first consult a physician for last illness?

Part C - AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Insured's Name	Date Of Birth	Social Security Number	Policy Number
Insured's Address			

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, Medical Information Bureau (MIB), or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the American Income Life Insurance Company (AIL) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco; but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that AIL may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with AIL.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to AIL, Attention: Claims Department, at the above address. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that AIL has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, AIL may not be able to process my claim or make any benefit payments. I have received a copy of this authorization.

Name and address of person(s) or category of person to whom this information will be sent	Name of person signing form:
American Income Life PO Box 2500 Waco, TX 76702	

Authority to sign on behalf of deceased.

___ Parent ___ Legal Guardian ___ Child ___ Spouse ___ Next of Kin

___ Executor of Estate ___ Other (please specify relationship to Insured) - _____

All items on this form have been completed and my questions about this form have been answered. American Income Life Insurance Company and I agree that this Claimant's Statement may be electronically signed. By typing my name below, I hereby agree that my electronic signature shall have the same effect as if it were handwritten. Further, I hereby attest that the information given herein is true and accurate to the best of my knowledge.

_____ _____

Signature of Patient/Beneficiary/Guardian or Personal Representative Date

Please make a copy of this authorization and retain for your record.

Part D - To be Completed by Physician **COMPLETE ONLY IF POLICY IS LESS THAN 2 YEARS OLD**

Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Deceased's name	Manner of Death	Date of Death
How long have you treated this patient?		
Were you the patient's medical attendant or adviser before last illness or infirmity? If so, when and for what disease?		
When was the patient diagnosed with the disease or impairment that resulted in death?		
Was the patient ever treated for drug or alcohol abuse? If so, please list dates and locations of treatment.		
Was the patient ever disabled? If so, when and for what reason?		

From what other disease or impairment has the patient suffered, and when?	Disease or Impairment	Duration
Was the patient confined to a hospital during the past 3 years? If so, provide the name and address of the hospital.		

Give names & addresses of the referring physicians or other practitioners who, to your knowledge, attended the patient during the past 5 years

Name	Address	Disease or Impairment	Dates

Physician's Name (PRINT)

Street Address

Physician's Signature

City State Zip

Fax Number

Phone Number

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Part E - To be completed by Beneficiary - COMPLETE ONLY IF POLICY IS LESS THAN 2 YEARS OLD.

Case # _____ App# _____ Operator # _____

*Patient's Name: _____

*Patient's Street Address: _____

*City: _____ *State: _____ *Zip: _____

*Patient's Date of Birth: _____ *SSN: _____

I hereby authorize disclosure of protected health information about me as follows:

(Name of facility or provider) _____

is hereby authorized to disclose medical information about me to:

AI Records
PO box 2608
Waco, TX 76702

Phone: (866) 922-6453
Fax: (866) 622-6458

The purpose of the requested disclosure is for INSURANCE.

Information to be disclosed:

- ☐ Discharge Summary
- ☐ Discharge Instructions
- ☐ History & Physical
- ☐ Consultations
- ☐ Operative Report
- ☐ ER Records
- ☐ X-Rays/Reports
- ☐ Lab Reports
- ☐ EKG/ECG Test
- ☐ Therapy Notes
- ☐ Progress Notes
- ☐ Medication Records
- ☐ Doctor's Notes
- ☐ Nurse's Notes
- ☐ HIV Testing

(Other) _____

_____

Dates of service _____

I understand that the information disclosed pursuant to this authorization may include information relating to treatment of drug or alcohol abuse, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Right to Revoke. I understand that I may revoke this authorization in writing to _____ at any time except to the extent that action has been taken in reliance on it, or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has a legal right to contest the policy or claim under the policy.

Right to Refuse to sign this Authorization. I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).

Redisclosure of Information. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal law.

Right to Inspect. I understand that I have the right to inspect the health information I have authorized to be disclosed by this authorization form.

Right to Receive a Copy of Authorization. I understand that I have the right to receive a signed copy of this form, if I so request.

This authorization expires on _____ or upon the following event: _____
If no date or event is specified, this authorization will expire six months from the date of signature.

_____
Signature of Patient or Patient's Personal Representative

_____
***Relationship to Patient (if not signed by Patient)**

_____
***Date of signature**

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