

INVESTORS HERITAGE *Life Insurance Company*

200 Capital Avenue • P.O. Box 717

FRANKFORT, KENTUCKY 40602

(800) 422-2011

Fax: (502) 223-6575

DEATH CLAIM STATEMENT

(To be completed by Creditor)
with Death Certificate attached

NAME OF INSURED: _____

LAST ADDRESS OF INSURED: _____

OCCUPATION AT DEATH: _____ Date of Death: _____

POLICY NO: _____ DATE OF POLICY: _____ TERM OF POLICY: _____

ORIGINAL AMOUNT OF POLICY: _____ LOAN NUMBER (Required) : _____

OF INSTALLMENTS DUE SINCE DATE INSURED:

_____ @ _____ = _____

OF EXTENSIONS OR DELINQUENT PAYMENTS (IF ANY) _____

GROSS BALANCE DUE _____

NET BALANCE DUE (FOR WHICH CLAIM IS MADE BY CREDITOR) _____

AMOUNT DUE SECOND BENEFICIARY _____

NAME OF SECOND BENEFICIARY _____

NAME & ADDRESS OF CREDITOR _____

I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Printed Name of Authorized Representative: _____

Phone Number: _____ Ext. _____ E-mail: _____

Signature : _____ OFFICIAL POSITION: _____

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ (Month) _____ (Day) _____ (Year)

NOTARY: _____

My Commission Expires: _____

**IF DEATH OCCURS WITHIN (2) YEARS OF THE DATE OF THE POLICY
THE BACK OF THIS FORM MUST BE COMPLETED AND SIGNED BY THE NEXT OF KIN.**

CLAIMANT STATEMENT

Instructions: Answer all questions completely, sign and date this claim form at the bottom. Return it with policy and certified copy of death certificate. If policy is lost indicate in space for additional information.

Name of Deceased	Policy Number
Date Of Birth	Date of Death
From what record was date of birth obtained?	Place of Death
Place of Birth	Cause of Death
If this policy is assigned, give particulars below.	When did health of deceased first become impaired?
	In last illness when did deceased first consult physician?
	On what date did deceased last attend to usual work.?

LIST ALL PHYSICIANS WHO ATTENDED OR PRESCRIBED FOR DECEASED WITHIN THE LAST FIVE YEARS PRECEDING DEATH

Name and Address (include Phone Number)	Dates of Attendance	Disease

LIST ALL HOSPITAL CONFINEMENTS DURING THE LAST FIVE YEARS

Name and Address of Hospital	Diagnosis	Month/Year

ADDITIONAL INFORMATION

The undersigned hereby makes claim to said insurance as beneficiary and agrees the written statements and affidavits of all 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 Proofs of death, and further agrees that the furnishing of this form or any of the forms supplemental thereto by the Company shall not constitute nor be considered an admission by it that there was any insurance in force on the life in question nor a waiver of any of its rights or defenses.

I expressly waive on behalf of myself and nay other party who shall have or claim any interest in any policy issued to the insured, all provisions of law forbidding physician or any other person who attended or examined the insured, or any hospital (including Veterans' Hospital) or sanitarium in which insured was confined, treated, or A photostatic copy of this authorization shall be considered as effective and valid as the original.

Claimant's Signature: _____ Phone No: _____

Address: _____ Age _____ Relationship to Deceased: _____

Social Security Number: _____ Witness to Signature: _____
 Date: _____