



Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (800) 370-5856
Fax (501) 235-8416

10 Year Term Life Proof of Death

For H.O. Use Only	
Eff	_____
PTD	_____
Benefits	_____

Important: Read Carefully
This form is to be completed upon the death of an insured and forwarded to US Able Life. In addition, an official Certified Death Certificate and the original insurance policy are required. If death was due to suicide, homicide or accidental means, a copy of the investigating officer's report is also required. By furnishing this form and investigating the claim, US Able Life shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.

STATEMENT OF CLAIM

Policy Number _____		Amount of Insurance _____	
Deceased's Full Name _____		Social Security # _____	
Address _____		City, State, Zip _____	
Date of Death _____		Place of Death _____	
Date of Birth _____		Place of Birth _____	

When did deceased first complain or give indication of last illness? _____

When did deceased first consult a physician for last illness? _____

Names and addresses of **ALL** physicians who attended or prescribed for deceased within 5 years preceding death:

Physician	Address	Dates of Attendance	Disease or Condition
_____	_____	_____	_____
_____	_____	_____	_____

Names and addresses of **ALL** hospitals where deceased was treated within 5 years preceding death:

Hospital	Address	Dates of Treatment	Disease or Condition
_____	_____	_____	_____
_____	_____	_____	_____

(Use Separate Sheet If More Space Is Needed)

I certify that the information furnished in support of this claim is true and correct.

Date _____ Beneficiary's Date of Birth _____ Beneficiary's Social Security # _____

Beneficiary Signature _____ Relationship To Deceased _____

Daytime Telephone _____ Beneficiary Name (Please Print or Type) _____

Address _____ City, State, Zip _____

Witness
Date _____ Signature _____ Daytime Telephone _____

Address _____ City, State, Zip _____

Authorization to Obtain Information

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of me or my health, past or present, to furnish such information to US Able Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original. I acknowledge that I have a right to a copy of this authorization upon request.

FRAUD WARNING: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Date _____ Signature of _____ Relationship To Deceased _____
Nearest Relative _____

Please have Attending Physician complete Page 2/reverse side.

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ATTENDING PHYSICIAN'S STATEMENT

**Please answer all questions.
This statement is to be furnished without expense to US Able Life.**

Deceased's full name	Age at Death
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Residence	City, State, Zip
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How long have you known the deceased?

Date of Death	Place of Death
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If death occurred in a hospital, please give name and address

When were you first consulted for the condition which directly or indirectly caused death?

What was the date of the first symptom or sign according to the clinical history?

How long, in your opinion, did this disease or impairment exist?

Contributory cause of Death	Duration
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Other Chronic Diseases or Impairments	Duration
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If death was due to suicide, homicide or accident, please state which _____
 Please describe briefly _____
 Was an official inquiry held? _____ Was an autopsy made? _____
 If so, please give particulars _____

Please give particulars of each condition for which you treated or advised the deceased for the past five years.

Disease	Date	Duration	Result
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please give names and addresses of all other physicians or practitioners who attended deceased within the 5 years preceding death:

Name	Address	City/State	Disease or Impairment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Physician's Signature	Date
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Physician's Name (Please Print or Type)	Degree
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Address	Telephone ()
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City	State	Zip	Fax ()
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