The United States Life Insurance Company
Attention: Policy Benefits-Life/MSN 2-K
3600 Route 66 • PO Box 1580
Neptune NJ 07754-1580

The United States Life Insurance Company In the City of New York
Member American General Financial Group

PROOF OF GROUP DEATH CLAIM

AS REQUIRED BY LAW, ANY PERSON WHO KNOWINGLY AND 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.

TO AVOID UNNECESSARY DELAY IN PROCESSING CLAIMS, PLEASE COMPLETE ALL BLANK AREAS AND SIGN FORM.

STATEMENT OF POLICYHOLDER

NAME OF DECEASED EMPLOYEE | *ADDRESS OF DECEASED EMPLOYEE* | *AMOUNT OF INSURANCE*

GROUP POLICY NO. | *CERTIFICATE NO.* | *NAME AND ADDRESS OF EMPLOYER* | *TELEPHONE NUMBER*

DATE OF EMPLOYEE'S
Birth | Death | Last day of full time active work for employer

REASON FOR STOPPING WORK
☐ Illness ☐ Leave of Absence ☐ Retirement ☐ Lay Off ☐ Other (Explain briefly)

☐ Union Employee ☐ Full Time
☐ Non-Union Employee ☐ Part Time Average Number of Hours Worked Per Week

IF DUE TO ILLNESS, DISABILITY BENEFITS WERE PAID
From To Carrier's Name

DURATION OF EMPLOYMENT | *EMPLOYEE'S JOB TITLE* | *WEEKLY EARNINGS* | *INSURANCE CLASS*
From Through

IF CONTRIBUTORY INSURANCE, TO WHAT DATE HAS EMPLOYEE'S CONTRIBUTION BEEN PAID?
Date

BENEFICIARY (IF ESTATE, CERTIFIED COPY OF COURT ORDER APPOINTING EXECUTOR OR ADMINISTRATOR SHOULD BE ATTACHED)
Name and Address Relationship Age

GUARDIAN (IF BENEFICIARY IS A MINOR, A CERTIFIED COPY OF COURT ORDER APPOINTING GUARDIAN SHOULD BE ATTACHED)
Full Name Address

SEND CHECK TO | *CURRENT DATE* | *SIGNATURE OF POLICYHOLDER'S OFFICIAL REPRESENTATIVE*

ATTENDING PHYSICIAN'S STATEMENT

If Decedent Was Disabled More Than 31 Days Prior to Death, Please Have This Statement Completed By The Physician Who Treated During This Disability.

FULL NAME OF DECEASED | *DATE OF DEATH* | *AGE*

PLACE OF DEATH | *DATE OF FIRST VISIT* | *DATE OF LAST VISIT*

IMMEDIATE CAUSE OF DEATH | *DURATION*

CONTRIBUTORY CAUSES OR COMPLICATIONS | *DURATION*

DEATH RESULTED FROM:
☐ Natural Causes ☐ Accident ☐ Suicide ☐ Homicide

IF DUE TO ACCIDENT, SUICIDE, OR HOMICIDE, DESCRIBE BRIEFLY:

Decedent was totally disabled and unable to perform work from to

I hereby certify that the above answers are true and complete to the best of my knowledge and belief.

DATE | *PRINT NAME*

TELEPHONE NUMBER | *SIGNATURE*

ADDRESS

THE CERTIFICATE OF INSURANCE AND ORIGINAL ENROLLMENT CARD (IF AVAILABLE) SHOULD ACCOMPANY THIS FORM

BY FURNISHING THIS BLANK AND INVESTIGATING THE CLAIM THE COMPANY SHALL NOT BE HELD TO ADMIT THE VALIDITY OF ANY CLAIM OR TO WAIVE THE BREACH OF ANY CONDITION OF THE POLICY

(Over)

CLAIMANT'S STATEMENT

FULL NAME OF DECEASED | *DATE OF BIRTH* | *DATE OF DEATH*

CAUSE OF DEATH | *PLACE OF DEATH*

WHEN DID DECEASED FIRST COMPLAIN OF, OR GIVE INDICATION OF HIS LAST ILLNESS?
Date

WHEN DID DECEASED FIRST CONSULT A PHYSICIAN FOR HIS LAST ILLNESS?
Date

WAS DEATH THE RESULT OF AN ACCIDENT? ☐ Yes ☐ No | *DATE OF ACCIDENT* | *PLACE OF ACCIDENT* | *DID ACCIDENT OCCUR IN COURSE OF EMPLOYMENT?*

DESCRIBE ACCIDENT BRIEFLY

NAMES AND ADDRESSES OF ALL PHYSICIANS WHO ATTENDED THE DECEASED AND OF ALL HOSPITALS AND INSTITUTIONS WHERE HE WAS TREATED DURING THE LAST ILLNESS AND DURING FIVE YEARS PRIOR THERETO:

Name	Address	Date	Disease or Condition

FACTS CONCERNING OTHER LIFE, HEALTH AND ACCIDENT INSURANCE CARRIED BY DECEASED.

Company	Policy Number	Amount of Insurance

ORIGINAL CERTIFICATE OF INSURANCE MUST BE RETURNED IF AVAILABLE
☐ Certificate enclosed ☐ Certificate cannot be located

IN WHAT CAPACITY DO YOU CLAIM THIS INSURANCE (IF ADMINISTRATOR, EXECUTOR OR GUARDIAN, ATTACH A COPY OF COURT ORDER APPOINTMENT.)

YOUR DATE OF BIRTH | *YOUR SOCIAL SECURITY NUMBER* | *ESTATE TAX I.D./TRUST TAX I.D. (PROVIDE IF CLAIM MADE BY ESTATE OR TRUST)*

I elect to receive payment by
- ☐ immediate availability of funds from an interest-bearing checking account* with free check-writing privileges.
- ☐ lump sum direct payment by check.
- ☐ other settlement option (Please Specify and if necessary, contact your insurance plan administrator for a description of other settlement options available) _____.

* If your proceeds are eligible and exceed the current applicable minimum ($5,000) set by the company, an interest-bearing checking account will be established in your name. You may immediately write a check for the full amount or leave your account open and draw money only as you need it. Meanwhile, the funds will earn interest at the variable rate currently effective for United States Life Instant Access Accounts payable through State Street Bank and Trust Company. The Instant Access Account is not available to estates, trusts or guardianships.

These statements are true and complete to the best of my knowledge and belief. I understand that the furnishing of forms by the Company does not constitute an admission that there is any insurance in force. I hereby authorize and request any hospital, physician, pharmacist, employer, insurance company or other person or entity to whom this is presented to furnish The United States Life Insurance Company or its representative, any and all information and records (or copies thereof) it may desire, specifically to include testing and/or treatment of Human Immunodeficiency (HIV) or AIDS, concerning the deceased and further agree that such information or records shall constitute and are hereby made a part of the Proofs of Death. A photostatic copy of this authorization shall be as valid as the original. Furthermore, in the event an Instant Access Account is opened, the Signature of Claimant(s) presented on this claim form will be used for signature verification.

Under penalty of perjury, I certify that the Social Security/Tax I.D. number provided on this form is true, correct, and complete. I understand that failure to furnish this number can subject me to back-up withholding. I certify that I am not now subject to back-up withholding.

DATE | *PRINT CLAIMANT'S NAME*

WITNESS | *SIGNATURE OF CLAIMANT, WITH TITLE, IF ANY*

ADDRESS | *ADDRESS*

ADDRESS | *ADDRESS*

DAYTIME TELEPHONE NUMBER

By furnishing this blank and investigating the claim, the Company shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.