USALLIANCE
-LIFE AND SECURITY COMPANY-™

CLAIM PACKET

1303 SW First American Pl, St 200 Topeka, Kansas 66604 | Phone: 866-953-4675 | Fax: 785-228-0202

CLAIM FORMS AND INSTRUCTIONS

This packet should be used to claim proceeds on a life insurance policy.
To file your claim with US Alliance Life & Security Company please follow these steps:

1) **Review the Claim Settlement Requirements and Instructions.**

2) **Complete the Life Insurance Claimant's Statement.** Each Beneficiary claiming benefits is required to complete a form and any additional forms requested.

3) **Provide an original certified death certificate.**

All forms and information should be mailed to:

US Alliance Life and Security Company
Attn: Claims
1303 SW First American Pl, St 200
Topeka, Kansas 66604

Fax: 785-228-0202
Email: service@usalliancelife.com (unsecure)

For inquiries, please call (866) 953-4675.

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Phone 785-228-0200 Fax 785-228-0202 Toll-free 866-953-4675
www.usalliancelife.com

Claim Settlement Requirements and Instructions

1. A Claimant's Statement must be completed by each beneficiary. We also need a Claimant's Health Statement for Life Insurance claims where the Insured passed away during the Contestable Period (within two years after the policy date) or when the policy contained the Accidental Death Benefit (ADB) rider and proceeds are being claimed under the rider in addition to the base policy.
2. A Certified Death Certificate will be required with the Claimant's Statement. One Certified copy will suffice, even if there are multiple beneficiaries. The Company reserves the right to require statements by all physicians who treated the Insured.
3. Newspaper clippings should be sent if the death resulted from other than natural causes. If an inquest or investigation was held by a Coroner or other Legal Official, a copy of the final report / verdict should be submitted.
4. The claim should be made by the appropriate (last named) beneficiary or beneficiaries. Please note:
    a. Each beneficiary must complete a Claimant's Statement. Mark the "lost policy" box if the policy is lost or cannot be located.
    b. If the proceeds are payable to the Estate, the Claimant's Statement must be completed by the executor or administrator of the Estate. A copy of the Court Order showing that the executor or administrator has qualified/been appointed must also be submitted. Be sure that the Tax Identification Number of the Estate is listed rather than the Social Security Number of the person completing the form.
    c. If the proceeds are payable to a minor or to a mentally incompetent person, a Claimant's Statement should be executed by the guardian or conservator of the estate of the minor or incompetent person. A copy of the court appointment must also be submitted. Be sure that the Social Security Number of the minor or incompetent person is listed rather than that of the guardian or conservator. Proceeds can be held at interest until a minor reaches the age of majority and can claim the proceeds on their own.
    d. If the proceeds are payable to a Trust, the Trustee or Successor Trustee as provided for in the agreement must complete the Claimant's Statement. Be sure the Tax Identification Number of the Trust is listed rather than the Social Security Number of the Trustee or person completing the form. A current Trust Verification Form must be on file or be completed.
5. If any beneficiary who would otherwise be entitled to all or a part of the proceeds is deceased, a certified copy of the Death Certificate of that beneficiary must be submitted.
6. For "class" beneficiary designations, such as "children of the insured", an Affidavit will be required certifying the names of the members of the class. It should include a statement certifying that the named members constitute all of the members of the class designated in the beneficiary designation, and should list each member's date of birth, and, if any have died, the affidavit must provide the date and place of death and be accompanied by a Certified Death Certificate for the deceased.
7. If the policy has been collaterally assigned by the Owner prior to the death of the Insured, a written statement from the collateral assignee will be required stating the amount of the assignee's interest in the proceeds.
8. If a named beneficiary has had a legal name change since being named (i.e., from marriage or divorce) a copy of the appropriate documentation of the name change should be provided. (Examples: Marriage Certificate, Divorce Decree, Court Order).
9. The Claimant's Statement and additional requirements should be mailed to US Alliance at the address shown above. Faxes or electronic filings of the Claimant's Statement can be accepted, but for certified documents such as the Certified Death Certificate, originals will be required.

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LIFE INSURANCE CLAIMANT'S STATEMENT

Completing This Form

Each Beneficiary claiming benefits is required to complete a form and any additional forms requested. Photocopies of this form are permitted. This form is supplied by the Company without prior verification of coverage and without any assurances made by the Company to the recipient that he, she or it will be the appropriate payee or beneficiary of such benefits. **Please provide an original certified death certificate.**

Information About the Deceased

Please print clearly or type. **Please provide the original policy or mark the box indicating the policy has been lost.**

Name of Deceased_____ Date of Birth_____

Policy Number(s)_____ Amount of Insurance_____

Social Security #_____ Date of Death_____ Place of Death_____

Other Names Used by Deceased_____

Address_____

[ ] The original policy is enclosed [ ] The original policy has been lost/cannot be located

Information About the Beneficiary

Name of Beneficiary_____

Social Security #_____ Relationship to Deceased_____

Age_____ Date of Birth_____ Telephone #_____

Address_____

Authorization and Signatures

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I permit (while this claim is pending) the release of any medical information about the deceased to US Alliance Life and Security Company and its representatives, including its reinsuring companies and other persons or groups performing business or legal services relating to this claim. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury the deceased had prior to or at the time of death. US Alliance Life and Security Company will use this information to find out if this claim is eligible. A copy of this authorization (one of which will be given to me by US Alliance Life and Security Company upon my request) will be as valid as the original. This authorization will be valid for a period of 24 months from the date signed.

I certify, under penalty of perjury, that the information and Social Security Number(s) provided above are true and correct. I also represent that no bankruptcy proceedings are now pending against this Insured (or his/her Estate) or the undersigned. It is further understood and agreed that by furnishing the claim forms, the Company does not waive any defense available to it. If I am claiming proceeds on behalf of a trust, I hereby certify that the trust is still valid and in place.

Beneficiary's Signature_____ Date_____

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