USALLIANCE
-LIFE AND SECURITY COMPANY-

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LIFE INSURANCE CLAIMANT'S HEALTH STATEMENT

To be used for Life Insurance Claims Made During the Contestable Period or when the Claim Includes an Accidental Death Benefit Rider Claim

Completing This Form

This form must accompany the Claimant's Statement(s) when the claim is being made for a death during the Contestable Period (the first two years after issue) or when the policy contained the Accidental Death Benefit rider and the beneficiaries are claiming proceeds under this rider in addition to claiming benefits under the base policy. The form should be completed by the next of kin or the person most knowledgeable of the of the Insured's health history. 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.

Information About the Decendent (Please print clearly or type)

1. Name of Insured (Decedent)_____ 2. Date of Birth_____
2. Policy Number(s)_____
3. Date of Death_____
4. Reason for completing Claimant's Health Statement
   [ ] Policy is in Contestable Period (death occurred within 2 years of policy date)
   [ ] Proceeds under Accidental Death Benefit rider are being claimed along with the proceeds of the base policy
5. Other Names Used by Decedent_____
6. Cause of Death_____
7. If death resulted from illness or disease, please provide the following:
   A. Date the underlying condition causing death was first treated_____
   B. Name and address of doctor/clinic first treating_____
      _____
8. If death resulted from an Accident, please provide the following:
   A. Date of accident_____
   B. Type of accident_____
   C. Location of accident_____
   D. Details of injury sustained_____
   E. Name and address of doctor/clinic treating_____
      _____
9. List name(s) and address(s) of the Decedent's primary or family doctor. If the Decedent did not have a family doctor, please advise the name and address of the clinic/hospital where care would normally be sought_____

_____
_____

10. Had the Decedent been in any hospital or care facility during the six months prior to death? [ ] Yes [ ] No
If "yes", please provide name(s) of hospital and/or care facility and dates of service_____
_____

11. Did the Decedent use any prescription medications prior to death? [ ] Yes [ ] No If "yes", list medications
_____

12. What is the name and address of the pharmacy used to fill prescriptions? _____ ____
_____

13. To your knowledge, did the Decedent smoke cigarettes or use other tobacco products prior to their death? [ ] Yes [ ] No
If "yes", what type of product and average quantity consumed?_____

14. Did the Decedent use medication or receive treatment for:

A. Diabetes	[ ] Yes [ ] No	E. Alzheimer's Disease	[ ] Yes [ ] No
B. Heart Disease	[ ] Yes [ ] No	F. Emphysema	[ ] Yes [ ] No
C. Stroke	[ ] Yes [ ] No	G. Kidney Disease	[ ] Yes [ ] No
D. Cancer	[ ] Yes [ ] No	H. Alcohol or Drug Treatment	[ ] Yes [ ] No

For any "yes" response above, please note the question letter and provide details about the prior care below, including dates:
_____
_____
_____
_____
_____

15. Print the full name, address and phone number of the Decedent's employer_____
_____
_____

16. Decedent's occupation_____

17. Date last worked_____

18. If death was caused by an accident, was the accident related to the Decedent's employment? [ ] Yes [ ] No

19. Please provide details of other life or accident insurance carried by the Decedent

Company Policy Date Amount of Insurance
_____
_____
_____
_____
_____

Declaration and Signatures

I declare that the facts stated on this form are complete and true to the best of my knowledge and belief.

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.

Signature_____ Date_____

Relationship (of person completing the form) to Decedent_____

CHS (7/13)