

REQUIRED: COMPLETE IN FULL. WE ARE UNABLE TO PROCESS THE CLAIM UNTIL ALL INFORMATION IS SUPPLIED. INCOMPLETE CLAIMANT'S STATEMENTS WILL BE RETURNED.

TEXAS SERVICE LIFE INSURANCE COMPANY
P.O. BOX 341899 Austin, Texas 78734 (512) 263-6977

CLAIMANT'S STATEMENT

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NAME OF DECEASED: _____ Policy Number: _____

Date & Place of Birth: _____ Date & Place of Death: _____

▶▶▶ REQUIRED: Check one of the following BOXES:

I HAVE ATTACHED THE ORIGINAL POLICY.

THE ORIGINAL POLICY IS NOT AVAILABLE. I hereby agree to return the original policy to the Home Office if it is found at a later date. I further agree to indemnify and hold harmless TEXAS SERVICE LIFE INSURANCE COMPANY from any and all losses it may incur as a result of the lost policy. This indemnification will be binding on my heirs, executors, administrators, successors and assignees.

I hereby authorize use or disclosure of protected health information about me as described below:

1. The following specific person/class of persons/facility is authorized to use or disclose information about me: ▶▶ **All medical providers or physicians who attended or treated the insured and all other papers called for by the instructions hereon (provide names, address, phone, dates of attendance, disease/conditions – continue on reverse if more space is needed)**

2. The following person (or class of persons) may receive disclosure of protected health information about me:
His/her/its name and address: **TEXAS SERVICE LIFE INSURANCE COMPANY, PO BOX 341899, AUSTIN TX 78734**
3. The specific information that should be disclosed is (please give dates of service if possible): _____
4. All medical records from _____ to _____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED *IN ORDER FOR THIS CLAIM TO BE PROCESSED, IT IS REQUIRED THAT YOU SIGN NEXT TO 'YES':** YES, DISCLOSE THIS INFORMATION _____
NO, DO NOT DISCLOSE THIS INFORMATION _____

5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
6. I may revoke this authorization by notifying TEXAS SERVICE LIFE INSURANCE COMPANY in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.
7. My purpose for/intended use of the information is SETTLEMENT OF LIFE/HEALTH INSURANCE CLAIM.
8. This authorization expires at the end of research, review and determination for this claim by Texas Service Life Insurance Company OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: **N/A**

The undersigned hereby makes claim to said insurance as **beneficiary** and agrees that 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 hereby waive on behalf of myself and any other party who shall have or claim any interest in any policy issued to the insured, all provisions of law forbidding any physician or any other person who attended or examined the insured, or any hospital (including Veteran's Hospital) or sanitarium in which insured was confined, treated, or examined, from disclosing any information or knowledge acquired thereby and I authorize the furnishing of all such information to the above named insurance company. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____ _____
SIGNATURE of Claimant - Beneficiary, Guardian or **DATE** of Claimant's **DESCRIPTION OF AUTHORITY TO ACT** for
Personal Representative of Patient's Estate Signature the Individual (relationship to Insured)

PRINT NAME: _____

Address: _____ **Telephone:** _____

A copy of this completed, signed and dated form must be given to the Individual or other signatory.