

TEXAS SERVICE LIFE INSURANCE COMPANY
P.O. BOX 341899 ♦ Austin, Texas 78734 ♦ (512) 637-4989

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 and Place of Birth

From what record was the date of birth obtained?

Date and Place of Death

Cause of Death

When did the health of deceased first become impaired?

In last illness on what date did deceased first consult a physician?

If any policy in this Company was assigned, please give particulars

▶▶▶ REQUIRED: CHECK ONE OF THE FOLLOWING:

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.

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 Beneficiary, Guardian or Personal Representative of Estate

DATE

PRINT NAME

RELATIONSHIP TO INSURED

ADDRESS

TELEPHONE