Clear Form

MOUNTAIN LIFE INSURANCE COMPANY

2416 Sir Barton Way Suite 110 Lexington, KY 40509 - (800) 888-6542

PROOF OF DEATH CLAIMANT'S STATEMENT

Before completing this statement, please read the instructions on the reverse side.

NOTE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. (In Arkansas) Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PART ONE - To be completed in full

Name of Deceased (Print in full)		Policy Number(s)
Date and Place of Birth	Date and Place of Death	Cause of Death
Name of Beneficiary (Print in Full)	Date of Birth	Relationship to Deceased
Address (Street, City, State, Zip)		Telephone Number

THE POLICY AND A CERTIFIED COPY OF THE DEATH CERTIFICATE MUST ACCOMPANY THIS CLAIM FORM. If the policy is lost, has been misplaced or inadvertently destroyed please indicate: _____

Method of Settlement ☐ Lump Sum ☐ Settlement Option - Specify (See reverse)

Beneficiary/Payee Signature (Required) X	Date	Social Security Number:

If Policy is assigned, name & address of Assignee: _____

Amount of Assignee's claim _____

Assignee's certification by: _____

PART TWO - To be completed only if: 1. Death has occurred within two years of original issue or reinstatement, or 2. Accidental death benefits are being claimed (Please furnish copy of accident/incident report.)

Date of accident or date deceased first complained of, or gave other indication of last illness.	Date deceased first consulted a physician for last illness.

Names and addresses of all physicians who attended to deceased and hospitals where treated during the past five years.

Name	Address (Street, City, State, Zip)	Dates	Disease or Condition

AUTHORIZATION

Name of Deceased	Your Relationship to Deceased

I hereby authorize any individual, physician, medical practitioner, hospital, clinic or other medical related facility, Medical Information Bureau, consumer reporting agency, rehabilitative assessment agency or government authority to furnish Mountain Life Insurance Company, its reinsurers or their representatives any information related to the health, medical history, diagnosis, and treatment (including copies of records) concerning the above referenced individual. These records should include any treatment regarding alcoholism, drug abuse, AIDS, HIV testing, AIDS related illness and psychiatric care or any physical or mental condition and/or treatment rendered.

This information is to be used for the purpose of determining insurance benefits. This authorization shall be valid for a period of one year from the date of signature.

I also authorize any employer, insurance company or insurance support organization to furnish information regarding benefits to which I may be entitled. I understand that I have a right to receive a copy of this authorization upon request. A Photocopy of this authorization shall be considered as valid as the original.

Signature of Next of Kin	Date
Address	Witness Signature

INSTRUCTIONS FOR COMPLETING PROOF OF DEATH

The furnishing of claim forms does not constitute an admission by this Company that there was any insurance in force at the time of death.

1. When the proceeds are payable to the Estate of the Insured, the claimant's statement must be completed by the Executor or Administrator, as the case may be. A certified copy of the Letters Testamentary or Letters of Administration must accompany this form.

2. When the proceeds of a policy are payable to a minor, the claimant's statement must be completed by the Legal Guardian of the child's estate. A certified copy of Letters of Guardianship must accompany this form. If no legal guardianship is established, the Proceeds will be held by the Company at interest, until age of majority.

3. When the proceeds of a policy are payable to a contingent beneficiary because of the prior death of the primary beneficiary, the contingent beneficiary is required to furnish a certificate of death covering the death of the primary beneficiary in addition to the other claim documents. This certificate may be obtained from public records.

4. When unnamed children (e.g., all surviving children) are designated as beneficiaries, the Company must be furnished with an affidavit giving the name, birth date and the residence address of all such children. The affidavit is to be made by a relative of the family having such information.

5. If there is more than one beneficiary, the names, birth dates and addresses of all other beneficiaries should be listed below.

Beneficiary (Signature Required)	Birth date	Telephone Social Security Number	Print Name and Address (Street, City, State, and Zip)
		[ ] - - -	
		[ ] - - -	
		[ ] - - -	
		[ ] - - -	
		[ ] - - -	

SETTLEMENT OPTIONS AVAILABLE

1. Lump sum (unless directed otherwise by the Insured).
2. Proceeds left on deposit at interest with right of withdrawal.
3. Installments of a specified amount ore for a specified length of time.
4. Installments providing a life income.

If one of these options is indicated on the reverse side of this form, full information will be furnished promptly.

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HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name of Proposed Insured (Please print)	Social Security Number	Birth Date

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company, medical facility, the MIB, Inc., the Veterans Administration, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose to Mountain Life Insurance Company, its reinsurer(s), and insurance supporting organizations and their representatives, my entire medical record, prescription history, medications prescribed and any other protected health information concerning me. This also includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I also authorize Mountain Life Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Mountain Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Mountain Life Insurance Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written notification to Mountain Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already replied on this Authorization to disclose information about me or to the extent that Mountain Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Mountain Life Insurance Company except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Mountain Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this Authorization upon request.

I authorize my employer, any consumer reporting agency, the Department of Motor Vehicles, other organizations, institutions or persons having any records or knowledge of me or my health to release any financial or personal data to Mountain Life Insurance Company or its reinsurers. This information may be used by underwriters, Company Officers, medical and claims personnel in evaluating applications and claims. They may also use it to consider Life and/or Disability insurance and/or benefits applied for by me. I understand this authorization is valid for 24 months from the date it is signed. A copy of it is also valid. I acknowledge having received a copy. I understand that I have the right to revoke this at any time. I also received a copy of **NOTICE OF INSURANCE INFORMATION PRACTICES**. I acknowledge receipt of the Conditional Receipt, if applicable, for Life and/or Disability insurance bearing the same date as this application and certify that I have read it, and its terms, conditions and limitations to which I agree.

Signature of Proposed Insured or Personal Representative	Date (MM/DD/YYYY)

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I authorize my employer, any consumer reporting agency, the Department of Motor Vehicles, other organizations, institutions or persons having any records or knowledge of me or my health to release any financial or personal datato Mountain Life Insurance Company or its reinsurers. This information may be used by underwriters, Company Officers, medical and claims personnel in evaluating applications and claims. They may also use it to consider Life and/or Disability insurance and/or benefits applied for by me. I understand this authorization is valid for 24 months from the date it is signed. A copy of it is also valid. I acknowledge having received a copy. I understand that I have the right to revoke this at any time. I also received a copy of **NOTICE OF INSURANCE INFORMATION PRACTICES**. I acknowledge receipt of the Conditional Receipt, if applicable, for Life and/or Disability insurance bearing the same date as this application and certify that I have read it, and its terms, conditions and limitations to which I agree.

Signature of Proposed Insured or Personal Representative	Date (MM/DD/YYYY)