P O Box 35768
Tulsa OK 74153
1-800-725-5433

DEATH BENEFITS CLAIM FORM

(CLAIM FORM MUST BE RETURNED WITH AN ORIGINAL CERTIFIED DEATH CERTIFICATE)

Section I

FULL NAME OF DECEASED____POLICY NUMBER(S)______________

SSN____________________DATE OF BIRTH OF DECEASED_____/_____/_____PLACE OF BIRTH______________

RESIDENCE ADDRESS OF DECEASED____

CITY:________________________________STATE:______________ZIP:______________

DATE OF DEATH____________PLACE OF DEATH______________CAUSE OF DEATH________________

Section II

OCCUPATION OF DECEASED________________________________DATE LAST WORKED_______/_______/_______

WHEN DID DECEASED FIRST COMPLAIN OR GIVE OTHER INDICATIONS OF LAST ILLNESS?

____

NAME/ADDRESSES OR PHONE NUMBERS OF ALL PHYSICIANS OR PRACTITIONERS WHO ATTENDED TO THE DECEASED WITHIN FIVE YEARS PRECEDING DEATH:

NAME	ADDRESS	PHONE NUMBER	DATE OF ATTENDANCE	DISEASE/CONDITION

Section III

The statements above are true and complete. I/we agree that the Company may rely upon them as part of the proofs of death under the policies numbered above. Any physician or practitioner who has attended ________________________________, Deceased Insured, and/or any hospital (including Veterans Administration Hospital) or other institution in which the Deceased Insured was treated or confined, is hereby authorized to furnish to Leaders Life Insurance Company or its representatives, any and all information and records with respect to any illness or injury, medical history, consultations, prescriptions or treatments pertaining to the Deceased Insured. Such information may be included as part of the proofs of death submitted to the Company. *I further understand that the information authorized for release may indicate the presence of a communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).*

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. Applicable to OK residents: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Applicable to AR and LA residents: Any person who knowing presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Applicable to KS residents: Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information may be guilty of insurance fraud as determined by a court of law.
Applicable to AL residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

NAME OF BENEFICIARY (PLEASE PRINT)______________________SIGNATURE__________________________
(BENEFICIARY/NEXT OF KIN)

DATE OF BIRTH_______/_____/_______SOCIAL SECURITY NUMBER________________________________

ADDRESS__________________________CITY:________________________STATE:____________ZIP__________

PHONE________________DATED AT__________________________THIS__________DAY OF________________
(CITY & STATE) (DAY) (MONTH & YEAR)

If claim is compensable, pay by: ___ Check ___ Bank Deposit (Please complete attached Direct Deposit Form.)

NOTARY

STATE OF__________________________) COUNTY OF________________________) **On this** ______________

day of __________________ **personally appeared before me the above named** ______________________________who

is known to me and who subscribed the foregoing statement before me and made Oath that the foregoing answers are each and all complete and true.
Notary Signature _________________________________ My Commission Expires__________________