Security Life of Denver Insurance Company
Benefits Division

Administered by
Vision Financial Corporation
17 Church Street
PO Box 506
Keene, New Hampshire 03431-0506

If you have any questions regarding our determination of your claim, or if you would like to appeal any determination, please contact our customer service department at 1-800-752-4729/ Fax (603) 357-4532

CLAIMANT'S STATEMENT — PROOFS OF DEATH

Please Read Instructions on Back Before Filling out this Statement

1a. Insured's (the "Deceased's") name in full: _____

1b. Other names insured may be known by (i.e. maiden name, hyphenated name, nickname, alias): _____

_____

2. Policy Number(s) under which the Deceased was insured	Policy Date	Amount
a.		
b.		
c.		

3. Date and Place of Deceased's birth: _____

4. Source from which date of birth was obtained (authentic record should be referred to): _____

5. Deceased's last residential address: _____

6. Deceased's last occupation: _____

7. Date and Place of Deceased's death: _____

8. Cause of death: _____

9. When did health of Deceased first become impaired: _____

10. List all diseases, ailments and injuries Deceased has had, and when: _____

_____

_____

_____

11. On what date did Deceased first consult a physician for last illness: _____

12. List the names and addresses of all physicians or practitioners who attended or prescribed for Deceased within five years preceding death:

Name	Addresses	Date of Attendance	Disease or Condition

13. List the names of all other Companies or Associations which issued life or accident insurance on the life of the Deceased, with the policy date and amount of each policy:

Companies or Associations	Policy Date	Listed Beneficiary	Amounts of Insurance

14. Was Deceased single or married at the time of death: _____

15. If married, when, where and to whom: _____

SEE REVERSE SIDE

Deceased's Name:_____

Policy Number(s) under which the Deceased was insured:_____

DECLARATION: The undersigned in submitting this Claimant's Statement claim the proceeds of the above-identified insurance policy (policies) under which the Deceased was insured. All statements and answers on the front side of this Statement are true and complete to the best of my (our) knowledge and belief. The undersigned agree that the written statements and affidavits of all physicians who attended or treated the Deceased and all other papers called or by the instructions below shall constitute a part of this claim.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I hereby authorize any hospital, practitioner, clinic, or other medically related facility, pharmacy, insurance company or government agency, or other person who has attended the deceased to disclose or furnish Security Life of Denver Insurance Company or its designee any and all medical information with respect to any illness or injury the Insured may have suffered including but not limited to medical history, drug/alcohol abuse, AIDS or AIDS related conditions; or other consultations prescriptions, diagnosis and treatment; or any information regarding benefits provided together with copies of all other medical records that may be requested. The information provided to Security Life of Denver Insurance Company or its designee is to be used solely for purposes of evaluating a claim. This Authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this Authorization by notifying Security Life of Denver in writing of my desire to do so. A photographic copy of the Authorization shall be as valid as the original regardless of the date signed. I understand that I or my representative may receive a copy of this Authorization by supplying policy number (s) and Insured's name in a written request to the company or its designee. **Important: To avoid delay, please sign authorization below.**

Note: Due to Internal Revenue Service requirements concerning social security number verification and backup withholding requirements, this form is required to be completed prior to claim payment. Remember, it is a crime to fill out this form with facts you know are false or to leave out facts you know are relevant and important. Please refer to the fraud notices on the reverse side for notice specific to your state. Check to be sure that all information is correct before signing.

Taxpayor Identification Number Certification

Federal law requires us to send to the Internal Revenue Service a percentage of any income you may be entitled to unless you certify under penalties of perjury that you have shown your correct Social Security Number and you have not been notified that you are subject to any Internal Revenue Service backup withholding order.

Under penalties of perjury, I certify that:

A. The Social Security Number shown below is my correct taxpayor identification number (or I am waiting for a number to be issued to me), and
B. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) The IRS has notified me that I am no longer subject to backup withholding, and
C. I am a U.S. person (including a U.S. resident alien).
D. The FATCA code entered on this form (if any) indicating that the payee is exempt from FATCA reporting is correct.

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding**.**

Sign here _____ Date:_____ ❑ Check here if address is new
Claimant

Street Address:_____City:_____State:_____ Zip: _____Telephone No. (____)_____

Relationship to Deceased_____Claimant's Date of Birth_____ SSN#_____
Witness Social Security Number

1. _____ 1._____ _____ _____
(Signature) Address_____

Day Telephone Number(_____)_____
Social Security Number

2. _____ 2._____ _____ _____
(Signature) Address_____

Day Telephone Number (_____)_____

If this policy is part of a qualified pension, profit-sharing, or HR-10 plan, we may require additional forms and the law may restrict the form of distribution.

INSTRUCTIONS

In all cases, the Proofs of Death required are as follows:

- CLAIMANT'S STATEMENT must be made by the persons whom the insurance is payable. If there is more than one beneficiary, all may join in one statement, or a separate form will be furnished for each if desired.
- When a policy is payable to a minor or a mentally incompetent person, the statement must be made by the guardian, an official certificate of whose appointment and qualifications must be furnished.
- If a policy has been assigned absolutely, the statement must be made by the assignee. If a policy has been collaterally assigned, both the beneficiary and the assigned must sign this statement. A sworn statement giving the extent of the assignee's interest in the policy must be furnished.
- A certified copy of the death certificate of any **deceased beneficiary** must be furnished. A newspaper clipping giving details of the death is required if available.

SEE PAGE 3 AND 4 FOR FRAUD NOTICES APPLICABLE TO YOUR STATE

- ATTENDING PHYSICIAN'S STATEMENT (when requested) must be made by every physician who attended the Deceased during the last illness. For this purpose, Security Life will furnish as many Attending Physician's Statements as are required.
- When an official inquiry as to cause of death has been made, a copy of the verdict or finding, duty certified, must be furnished with this statement.
- A CERTIFIED COPY OF THE CERTIFICATE OF DEATH of the deceased, as shown by the books of the Health Department, Registrar, County Clerk, or other official having charge of such records must be furnished.
- Every question must be distinctly and fully answered. Security Life reserves the right to require or to obtain further information should it be deemed necessary.
- In issuing claim forms for the convenience of the Claimant, Security Life of Denver Insurance Company does not admit any liability or waive any of its rights.

ILLINOIS INTEREST STATEMENT: For contracts issued in and residents of Illinois, unless payment is made within fifteen (15) days from the date of receipt by the company of due proof of loss, interest shall accrue on the proceeds payable because of the death of the insured, from date of death, at the rate of 9% on the total amount payable or the face amount if payments are to made in installments until the total payment or the first installment is paid.

FRAUD WARNINGS BY STATE

NOTICE IN ALABAMA: 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.

NOTICE IN ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY AND NEW MEXICO: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE, IDAHO, INDIANA, MINNESOTA, AND OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: FRAUD NOTICE: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

NOTICE IN NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: 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.

NOTICE IN OREGON: Any person who makes intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousands dollars ($5,000), not to exceed ten thousands dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE AND WASHINGTON: 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.

NOTICE IN TEXAS: 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.

NOTICE IN WEST VIRGINIA AND RHODE ISLAND: Any person who knowingly 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.