

**STATEMENT OF CLAIMANT**  
TO BE COMPLETED FOR LIFE AND/OR ANNUITY BENEFITS

In furnishing this form, the Company reserves all of its rights under the Policy and waives none of the conditions of the Policy.

**PART I INSURED'S IDENTIFICATION**

Account No. \_\_\_\_\_ Social Security No \_\_\_\_\_  
Insured's name in full \_\_\_\_\_ Also known as: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Date of Death \_\_\_\_\_  
Occupation \_\_\_\_\_ Date Last Worked \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_

**PART II DEPENDENT IDENTIFICATION**

**If claim is on a dependent:**  
Name of Deceased \_\_\_\_\_ Relationship to Insured \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_ Date of Death \_\_\_\_\_  
Employer \_\_\_\_\_  
Address: \_\_\_\_\_  
Occupation \_\_\_\_\_ Date last Worked: \_\_\_\_\_

**PART III CLAIMANT'S IDENTIFICATION**

Your Name \_\_\_\_\_ Relationship to Deceased \_\_\_\_\_  
Social Security # \_\_\_\_\_ Telephone # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Do you claim this insurance as  Beneficiary  Executor  Guardian  Other capacity  
**If Executor or Administrator**, attach Letters Testamentary or Letters of Administration.

**PART IV MEDICAL INFORMATION**

Date Deceased first consulted a physician for his last illness \_\_\_\_\_  
Names and addresses of all physicians who treated the deceased and of all hospitals or institutions where the insured was treated during the last five years: (Attach additional pages if needed)  

<u>Name of Physician or Hospital</u>	<u>Address</u>	<u>Dates Treated</u>	<u>Conditions</u>

**PART V ACCIDENTS (Complete only if loss is the result of accidental injury)**

Where did the accident happen? \_\_\_\_\_ Date of Accident \_\_\_\_\_  
How did the accident happen? \_\_\_\_\_  
Was the injury received in the course of employment?  YES  NO

**PART VI CERTIFICATION**

I certify the above statements are true and complete to the best of my knowledge.

**Warning:** 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.

Signed \_\_\_\_\_ Date: \_\_\_\_\_

(Claimant/Beneficiary)

Please complete and sign the authorization on the reverse of this form.

PART VII AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about the deceased's health including the deceased's entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC) who are involved in determining whether the deceased is eligible for benefits under this insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, and k) Workers' Compensation Carrier. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

**NOTICE:** Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which the deceased may have been treated. For Maine residents, information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, AIDS/ARC (Acquired Immune Deficiency Syndrome /AIDS Related Complex) or other conditions for which the deceased may have been treated. This authorization excludes disclosure of the result of a test for HIV if the deceased has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the deceased had AIDS. For Vermont residents, this authorization does not require disclosure of prior HIV-related tests. For Wisconsin residents, results of AIDS/HIV test do not need to be reported if they were done at any anonymous counseling and testing site, if the test was not an FDA-licensed blood test, or through the use of a home test kit. For Arizona residents, release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from the date shown below.

**I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or a delay of benefits.** I understand that I may revoke this authorization at any time by writing to AFES Benefits Department, PO Box 25160, Oklahoma City, OK 73125-0160 or by calling, toll-free, 1-800-662-1113. I understand that my right to revoke this authorization is limited to the extent that: AFAC has taken action in reliance on the authorization; or, the law provides AFAC with the right to contest the deceased's insurance coverage or a claim under the deceased's insurance coverage. A copy of this authorization will be as valid as the original.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

This authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

Signature of Personal Representative/Beneficiary	Printed Name (Deceased)	Date of Birth (Deceased)
Relationship to Deceased	AFA Account#	Date

*If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.*

**Please retain a copy for your personal records, or you may request a copy from our Company.**