

## Loss Of Life Beneficiary Statement

- A.** When submitting a claim for benefits due to loss of life, submit the following with this completed form:
1. **Certified copy of the death certificate.**
  2. If death was due to accident, a copy of the **coroner's report, accident report** and newspaper clippings.
- B.** If the beneficiary is:
1. A minor or incompetent - If a guardian has been appointed, submit a certified copy of the appointment of the guardian of the estate of the minor or incompetent. If no guardian has been appointed, furnish full name and address of person who has custody of the minor or incompetent.
  2. An Estate - Submit a certified copy of the appointment of the Executor or Administrator. If estate is not to be probated furnish name, address and relationship of next-of-kin.
  3. Deceased - Submit a certified copy of the beneficiary's Death Certificate.

### Section 1: Information about the deceased insured

Full name of insured as it appears on the policy		Policy number(s)	Insurance Amount
Complete Address		Date of Birth	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
Occupation at time of death	Date of death	Place of death	
Cause of death			
If death was due to an accident, provide details of the accident			Date of accident
If death was due to an illness, when did the deceased first give indication of the illness?		-first consult a physician for the illness?	

### Section 2: Authorization and Beneficiary Information

I hereby authorize and request that John Alden Life Insurance Company or its representatives be provided with any and all facts, dates, and copies of records concerning the history and physical and mental records of the deceased.

**I UNDERSTAND** the information obtained by use of this authorization will be used by John Alden Life Insurance Company or its representative to determine eligibility benefits under existing coverage. Any information obtained will not be released by John Alden Life Insurance Company or its representative to any person or organization **EXCEPT** to reinsuring companies, or other persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required, or as I may further authorize.

**I KNOW** that I may request a copy of this Authorization. **I AGREE** that a Photocopy/Fax/E-mail copy of this document shall be as valid as the original. **I AGREE** this Authorization shall be valid for the period required to process the claim.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_  
City, State Day Month Year

\_\_\_\_\_  
Beneficiary Signature (Parent Or Guardian Must Sign For A Minor) Witness Signature

\_\_\_\_\_  
Print Beneficiary's Name Date of Birth Social Security No. Phone No.

\_\_\_\_\_  
Address City State Zip

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.