KEMPER
Home Service Companies

DEATH CLAIM - CLAIMANT'S STATEMENT

SUBMIT CLAIM TO: HOME SERVICE INSURANCE SERVICES
12115 LACKLAND RD
ST. LOUIS, MO 63146

INDICATE THE COMPANY FOR WHICH CLAIM IS BEING MADE:

- ❑ UNITED INSURANCE COMPANY OF AMERICA
- ❑ UNION NATIONAL LIFE INSURANCE COMPANY
- ❑ ATLANTA LIFE INSURANCE COMPANY
- ❑ THE RELIABLE LIFE INSURANCE COMPANY
- ❑ MUTUAL SAVINGS LIFE INSURANCE COMPANY

PLEASE TYPE OR PRINT THE FOLLOWING INFORMATION

Name of Insured (Deceased)_____ Social Security No. _____

List below any other names by which the Insured was known (include maiden name, nicknames, initials, common names, etc.)

(_____) (_____)

(_____) (_____)

Date of Death: _____ Date of Birth: _____

Address of Insured: (Street Address): _____

(City)_____(State)_____ (Zip Code) _____

List any other states where the insured may have lived: _____

PROVIDE THE NUMBERS OF ALL POLICIES ON WHICH CLAIM IS BEING FILED:

Policy Prefix	Policy Number	Policy Prefix	Policy Number

BENEFICIARY INFORMATION

Name of Beneficiary: _____Relationship to insured_____

Address: (Street Address) _____

(City) _____ (State) _____ (Zip Code) _____

Social Security # _____ Phone # (_____)_____ Date of Birth _____

Name of Beneficiary: _____Relationship to insured_____

Address: (Street Address) _____

(City) _____ (State) _____ (Zip Code) _____

Social Security # _____ Phone # (_____)_____ Date of Birth _____

ASSIGNMENT OF PROCEEDS OF INSURANCE

Have you or anyone else assigned all or any portion of the proceeds of any policy to a funeral home or any other party?
❑Yes ❑No If yes, provide the name and address of such firm or person _____

_____

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DEATH CLAIM - CLAIMANT'S STATEMENT (PART TWO)

Manner of Death:

- ❑ Natural Causes (such as heart attack, cancer, etc.)
- ❑ Accidental (such as motor vehicle accident, drug overdose, etc.)
- ❑ Homicide
- ❑ Suicide

IF ANY POLICY IS LESS THAN TWO YEARS OLD OR IF THE DEATH WAS BY ACCIDENTAL MEANS, LIST THE DOCTORS/HOSPITALS THAT TREATED THE INSURED/DECEASED DURING THE PAST FIVE YEARS.

Name of Doctor(s) or Hospital(s):_____

Address:_____City: _____

State:_____ Zip Code:_____ Telephone No.:_____

Name of Doctor(s) or Hospital(s): _____

Address:_____City: _____

State:_____ Zip Code:_____Telephone No.: _____

Name of Doctor(s) or Hospital(s): _____

Address: _____City: _____

State:_____ Zip Code: _____Telephone No.: _____

Any person, who, with the 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 may have violated the state law.

CLAIM / MEDICAL AUTHORIZATION

I/We affirm and declare the above statements to be true and correct to the best of my/our knowledge and belief. I/We will furnish any additional proof the Company may request.

Upon presentation of the original (or a photocopy) of this signed authorization, I/We authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy, dentist, coroner/medical examiner, insurance or reinsuring company, the MIB, Inc. (formerly the Medical Information Bureau) consumer reporting agency, employer, or other medical or medically related facility or other person or entity possessing medical or non-medical information or having any records or knowledge of the deceased or the deceased's health of the deceased insured (_____) to give to the Claims Department of _____ (Insurance Company), or an authorized representative, any and all such information, including information about drug, alcohol, psychiatric, HIV infection, or AIDS related information for the purpose of assessing the pending claim. This authorization may be used for the duration of the pending claim. A photostatic copy of this authorization shall be as valid as the original.

_____ _____

Signature of Claimant/Beneficiary Date Signed

_____

Relationship to Deceased

_____ _____

Signature of Claimant/Beneficiary Date Signed

_____

Relationship to Deceased