Starmount Life extends its sympathy regarding your loss, and hopes you understand the necessity of this form completion. Your cooperation and patronage are appreciated.

PROOF OF DEATH
LIFE INSURANCE CLAIM
CLAIMANT'S STATEMENT

FULL NAME OF DECEASED		RESIDENT ADDRESS OF DECEASED	
POLICY NUMBER(S)	AMOUNT(S) $	OCCUPATION AT DEATH	DATE LAST WORKED / /
SOCIAL SECURITY # OF DECEASED (send copy of card) ____ ____ ____ - ____ ____ - ____ ____ ____ ____		DRIVER'S LICENSE # OF DECEASED (a copy is required)	ISSUED IN STATE OF:

ATTACH THE COMPLETE ORIGINAL POLICY/POLICIES TO THIS FORM (keep a copy for your records). Done? Yes ☐ No ☐	Attach a copy of the birth certificate or other official record of birth, Social Security card, driver's license, and a certified death certificate. This is required.	DATE OF BIRTH OF DECEASED / /	PLACE OF BIRTH

When did Deceased first complain of or give other indications of the condition or illness which eventually led to death? Mo___Day___Year___

When did Deceased first consult a physician for the condition or illness which eventually led to death? Mo___ Day___ Year___

To the best of your knowledge, was all information provided in obtaining this insurance complete and true? Yes ☐ No ☐

Do you know any reason this claim should not be paid? Yes ☐ No ☐

DATE OF DEATH / /	Was the deceased your natural or legally adopted child or grandchild? Yes ☐ No ☐	CAUSE OF DEATH: Natural ☐ Accidental ☐ Other ☐ Details:	In last 2 years, Deceased smoked (or chewed tobacco): ☐ 1 pack per day or less ☐ More than 1 pack per day ☐ Did not smoke.
PLACE OF DEATH	Name of funeral home used:	Address (Street, City, State, Zip):	Phone ( )

Name of all physicians or practitioners who attended or prescribed for Deceased within five years preceding death (use back of form if necessary):

NAMES	ADDRESSES	DATES OF ATTENDANCE	DISEASE OR CONDITION

List each Life, Health, and Accident insurance policy carried by Deceased with other companies (use back of form if necessary):

Health, Medicare or Medicare Supplement Insurance COMPANY NAME	POLICY DATE	INSURANCE POLICY #	Life Insurance COMPANY NAME	POLICY DATE	INSURANCE POLICY #	INSURANCE AMOUNT	
						LIFE	ACCIDENT

The information above is true and complete. I/we agree that Starmount Life Insurance Company may rely upon this information as part of the proofs of death under the policies numbered above. I am the rightful beneficiary and claim the insurance monies of the Deceased shown above. To the best of my knowledge all statements and information sent by the Deceased to Starmount Life Insurance Company were complete and accurate. I know of no reason why this claim should not be paid, and request the monies be sent. I understand that misstatement of information on this form in order to collect monies not otherwise owed is a felony, and would subject me to criminal prosecution.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic, or other medical related facility, insurance company, the Medical Information Bureau or other organization or person that has any medical record of me, my health, or any member of my family to give Starmount Life any such information. This includes knowledge about drug abuse, alcoholism or mental illness, and HIV and/or AIDS status. Although information about drug abuse, alcoholism or mental illness, and HIV and/or AIDS status may be protected by government regulation, I allow Starmount to collect it to determine the Deceased's insurability at the policy's issuance date. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining this authorization. I understand that I am entitled to a copy of the information obtained; that this authorization will expire in 30 months (KS,NM,OK,WV, in 24 months), (MN, in 26 months), (in AZ, 180 days to disclose HIV-related information), but can be revoked at any time with written notification from a beneficiary. A copy is as valid as the original. I am also aware that the records may be subject to re-disclosure by the recipient, and no longer protected by federal privacy regulations. 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 in the third degree.

Date Signed / /	Signature of Beneficiary (only)	Relationship	Social Security Number __ __ __ - __ __ - __ __ __ __	Telephone Number ( )______-__________

BENEFICIARY'S FULL ADDRESS (including street #, apt. #, city, state & zip)	BENEFICIARY NAME (Print)	BENEFICIARY DATE OF BIRTH ____/____/____

IMPORTANT: A CERTIFIED COPY OF THE DEATH CERTIFICATE MUST ACCOMPANY THIS FORM (unless you have already sent it to us).

PLEASE ATTACH POLICY OR POLICIES (keep a copy), COPIES OF BIRTH CERTIFICATE, DRIVER'S LICENSE & SOCIAL SECURITY CARD.

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY. THANK YOU.