LUSO-AMERICAN FINANCIAL

A Fraternal Benefit Society

CLAIMANT'S STATEMENT & PROOF OF DEATH

**** A CERTIFIED COPY of the deceased's Death Certificate MUST accompany this form. (see Item 2.a. on reverse side) ****

This form is supplied upon request without verification of the status of the insurance.

1. _____ _____

   Deceased's Name in Full — Marital Status

   _____

   Deceased's Residence

   _____ _____ _____

   Deceased's Date of Birth — Deceased's Place of Birth — Deceased's Social Security Number

2. Policy Numbers for this policyholder under which a Claim is filed:

Number	Face Amount	Beneficiaries, Owners or Assignees (list all)
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. In what capacity or by what title do you make this Claim (relationship)? _____

4. Complete this section if policy ***is less than two years old*** or if ***Accidental Death Benefits are being claimed***.

   Give names and address of all physicians who attended deceased during the last THREE years prior thereto:

Physicians Name:	Physician's Address:	Dates of Attendance:	Disease or Condition:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

For your protection, California law requires the following to appear on this form. 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.

These statements are true and complete to the best of my knowledge. I authorize any physician, hospital or other organization to furnish Luso-American Financial or its representatives and information it may request regarding the medical history, treatment and cause of death of the deceased.

Claimant/Beneficiary Printed Name: _____ Relationship to Insured: _____

Social Security Number: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ E-Mail Address: _____

Claimant/Beneficiary Signature: _____ Date signed: _____

LUSO-AMERICAN FINANCIAL • HOME OFFICE • 7080 Donlon Way, Suite 200 Dublin, California 94568 • TOLL FREE: 877-525-LUSO • 925-828-4884 • FAX: 925-828-4554 • WWW.LUSO-AMERICAN.ORG
LUSO-East Office • 128 Union Street, Suite 100 New Bedford, MA 02740 • TOLL FREE: 800-378-0566 • FAX:774-202-1275

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GENERAL INSTRUCTIONS

1. **Claimant's Statement**. This **ORIGINAL** Claimant Statement must be completed by the Beneficiary and then mailed to Luso-American Fin., 7080 Donlon Way Suite 200, Dublin, CA 94568, *Attn: Claims Department*.
   a. If there is ***more than one beneficiary***, each must complete a ***separate Statement***.
2. **Death Certificate**. A **Certified copy of the death certificate is to be furnished with this form**.
   a. **A certified copy of a death certificate** is issued by your local county Records Office & will have a ***raised seal***, will show the ***"wet/live" signature*** of the **Local Registrar** and will be ***printed on records office security paper***.
3. **Newspaper Account**. If available, a newspaper account of the death should be submitted.
4. **Policy**. The ***original policy should be sent with this Statement***. If the policy is not available, please provide an explanation if not enclosed. Additional forms may be required.

SPECIAL INSTRUCTIONS

Estate Beneficiary. The Statement must be completed by the Executor or the Administrator, and a certified copy of appointment must be furnished.

Minor Beneficiary. The Statement is to be completed by the legally appointed guardian of the Estate of the minor and an official certificate of the guardian's appointment must be furnished.

Predeceased Beneficiary. When a beneficiary has predeceased the insured, a certified copy of the death certificate is to be furnished.

Class Beneficiaries. An affidavit showing the names and dates of birth of each must be submitted.

Assignee. The Statement is to be completed by the assignee. If the assignment is no longer effective, a release of assignment from the assignee should be submitted. If collaterally assigned, the Statement should be completed by both the beneficiary and assignee and the amount claimed by the assignee indicated on the Statement.

ACCIDENTAL DEATH REPORT

If the policy provides for additional benefits in the event that the cause of the insured's death was accidental, fully complete the following statement and send a copy of any official report made as a result of an inquiry or investigation of the accident.

Date of Accident: _____ Time of Accident: _____

Place of Accident: _____

Did accident arise out of or in the course of deceased's employment? _____

Explain what the deceased was doing when Accident occurred: _____

_____

Explain the apparent cause of the Accident: _____

_____

Type of official report of the accident being sent? (E.g. Police Report; Medical Examiner Report)

_____

Date: _____ Completed by (Print): _____ Signature: _____

The Company reserves the right to require and obtain any additional statements and information that it deems necessary.

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