

CLAIMANT'S STATEMENT - PROOF OF DEATH

(See Reverse Side for Instructions)

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

1. Deceased's Name Marital Status
 Residence
 Place of Birth Date of Birth
 Source from which date of Birth obtained

2. Policy Numbers under which payment is requested:

Number	Amount	Beneficiaries, Owners or Assignees
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.....
.....

3. Date, Place and Cause of Death. (If injury, also complete Accidental Death Report on reverse side.)	Date:	Place:
	Cause:	

4. Date of onset of last illness: Date last worked:
 Occupation of Deceased at Death:

5. In what capacity or by what title do you make this claim? Amount of portion of proceeds claimed by you.	
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6. If Settlement Options are available, state type of settlement desired:	
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7. Complete if policy is less than two years old or if Accidental Death Benefits are claimed.

Physicians attending deceased during last three years	Dates of Attendance	Disease or Condition
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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 Life Insurance Society or its representatives any information it may request regarding the medical history, treatment and cause of death of the deceased.

Date: _____

Signature _____ Age _____

Witness: Address _____

City _____ State _____ Zip Code _____

Social Security Number _____