

(Before completing, read instructions on back of this form)

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits.

By furnishing forms and investigating the claim, the Company does not admit that there is any insurance in force and does not waive any of its rights of defenses.

Policies of this Company under which claim is being made:

Group Number / Carrier Number: _____ Name of Employer: _____

Basic Life: _____ Basic AD&D: _____

Supplemental Life: _____ Supplemental AD&D: _____ Dependent Life: _____

Employer's Statement

1. **Insured's:** (a) name in full _____
 (b) Residence address _____
 (c) Occupation (If retired, please designate and list prior occupation) _____
 (d) Date of Hire _____ (e) Last Day Worked _____
 (f) Average Hours worked/week _____ (g) Annual Salary _____
2. Authorized Individual (Type or Print) _____ Title/Position _____
 Signature _____ Date _____ Phone Number _____

1. (a) **Deceased's:** name in full _____
 (b) Date of BIRTH of deceased _____ Place of Birth _____
 (c) Where was date of birth obtained? (Birth or Baptismal record should be consulted if possible) _____
 2. (a) Date of DEATH _____ (b) Place of death _____
 (c) Cause of death _____
- If cause of death or injury was the result of an accident, a copy of the accident report is required before any claim can be made.**
3. (a) When did deceased first complain or give other indications of his/her last illness? _____
 (b) When did deceased first consult a physician for his/her last illness? _____
 4. Names and Addresses of all physicians or practitioners who attended or prescribed for deceased within the five years preceding death (use a separate sheet of paper if necessary):

Beneficiaries' Statement

Names	Addresses	Dates of Attendance	Disease or Condition
_____	_____	_____	_____
_____	_____	_____	_____

Beneficiary No. 1

Beneficiary No. 2

Name _____	Name _____
Date of Birth _____ Relationship _____	Date of Birth _____ Relationship _____
Social Security Number _____	Social Security Number _____
Complete Address _____	Complete Address _____
Signature _____ Date _____	Signature _____ Date _____

Authorization

I agree that the written statements of all physicians who attended or treated the deceased and all other papers called for by the Company shall constitute and they are hereby made a part of these proofs of death and further agree that all provisions of law forbidding any physician or other person who attended deceased from disclosing any knowledge or information acquired by him are hereby waived.

I hereby authorized any physicians, medical practitioner, hospital, clinic, other medical or medically related health care facility or health care provider, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency or employer, having information available concerning the diagnosis, treatment or prognosis of any physical or mental condition of the deceased, to give to Madison National Life Insurance Company, hereafter called the Company, or its legal representative any and all such information.

I understand the information obtained by use of this Authorization will be used by the Company to determine eligibility for benefits under an existing policy. Any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application or claim or as may be otherwise lawfully required or as I may further authorize.

I understand that I may receive a copy of this authorization upon request, agree that a photographic copy of this Authorization shall be as valid as the original and agree that this Authorization shall be valid for two years from the date shown below.

_____, 20_____
Date

Signature of Beneficiary

INSTRUCTIONS

In EVERY CASE:

- 1) A CERTIFIED COPY OF THE DEATH CERTIFICATE must be furnished.
- 2) A copy of the most current beneficiary designation or change card must be furnished.
- 3) A copy of the employee's time card or attendance record from the last two weeks worked must be furnished unless the employee is retired.
- 4) A newspaper clipping of the death or burial should also be forwarded if possible.

The CLAIMANT'S STATEMENT:

- 1) If the death is the result of an accident, claimants must include a copy of the official accident report when making a claim for benefits.
- 2) If there is more than one beneficiary, each must fill out the personal beneficiary information.
- 3) If the policy is payable to the estate or to the executors or administrators of the insured, the statement should be completed by the executor or administrator and a certificate of whose appointment and qualifications must be furnished.
- 4) If the policy is payable to a minor or a mentally incompetent person, the statement should be executed by the court appointed legal guardian and a certificate of whose appointment and qualifications must be furnished.
- 5) If the policy has been assigned absolutely both in form and in fact, the statement should be completed by the assignee. If collaterally assigned, the statement should be completed by both the beneficiary and assignee and a statement agreed to by both parties should be furnished showing the extent of the assignee's interest in the policy.
- 6) If any beneficiary is deceased, a certified copy of the death certificate should be furnished.