



CLAIMANT'S STATEMENT OF DEATH

1. Name of Deceased.		Soc. Sec. No.	2. Age at death.	3. If a female and married, give maiden name.	
4. Address at time of death.			5. Date of death.	6. Date of deceased's birth.	
7. Place of birth. City _____ State _____		8. Place of death. City _____ State _____			
9. Name of claimant.		Are you the beneficiary?	Relationship.	Age.	
10. Who paid the premiums?		11. Who pays the burial expenses?		12. Cause of death.	
13. If death due to accident, give date.		14. State fully how accident occurred.			
15. Where did accident occur?					
16. Name of last employer.		17. Address of last employer. No. _____ Street _____ City _____ State _____			
18. Was deceased married?		19. If married, give address of husband or wife. No. _____ Street _____ City _____ State _____			
20. List here all insurance with <i>this</i> Company. Number of Policy _____ Amount of Insurance _____		21. List here names and ages of all children of deceased.			

Complete questions 22 only if the policy is less than two years old.

22. Medical treatment received by deceased during past three years.

Name of Doctor	Date Treated	For What Treated	Place of Treatment

I certify that the above stated information is true to the best of my knowledge and belief. I authorize the Columbian Financial Group, its agents, employees, insurance support organizations and their representatives to obtain information regarding the deceased for the purpose of evaluating this claim for life insurance proceeds. This information may include but is not limited to (a) age, (b) medical history, condition and care, (c) physical and mental health, (d) occupation, (e) income, (f) avocations, (g) driving record, (h) other personal characteristics, including the use of alcohol, drugs, and tobacco, and (i) other insurance. This authorization extends to information on the use of alcohol, drugs, and tobacco; the diagnosis or treatment of HIV infection or acquired immunodeficiency syndrome (AIDS) or other sexually transmitted diseases; and the diagnosis and treatment of mental illness.

I waive the physician - patient privilege of the deceased and I authorize any physician, medical professional, hospital, clinic, medical facility, the Veterans Administration, governmental agency, employer, consumer reporting agency, organization, individual, or person, or other insurance company, to release information about the deceased to the Columbian Financial Group, its agents, employees, insurance support organizations and their representatives for the purpose of providing the Columbian Financial Group the necessary documentation in examining this claim for benefits. No other release may be made except as allowed by law or as I further authorize. A photocopy of this form shall be valid as the original.

Indicate here if the original policy has been
 Lost Destroyed

Signature of Beneficiary _____

Soc. Sec. No. _____ Phone (_____) _____

Address _____
 No. _____ Street _____ City _____ State _____ Zip _____

SPECIAL NOTICE FOR OHIO RESIDENTS: Pursuant to Ohio Revised Code Section 3999.21: Any person who, with 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 is guilty of insurance fraud.

 Witness to Beneficiary's Signature