



Transamerica Life Insurance Company
4333 Edgewood Road NE
Cedar Rapids, IA 52499

CLAIMANT'S STATEMENT

Date: _____

To the above Insurance Company: I hereby make claim under the policy/certificate or policies/certificates of the Company, numbered as follows: _____ Claim # _____

1. a. Name of deceased in full: _____
 b. Last known address of deceased: _____
 c. Occupation at death: _____
2. a. Date of death: _____ b. Place of death: _____
 c. Cause of death: _____ d. If death was due to suicide, homicide, or accident, state which and describe briefly: _____
3. a. BIRTH date of deceased: _____ State of Birth: _____
 b. From what source was the above date of birth obtained (from family record, certificate of birth, or otherwise)? _____
4. a. What is the beneficiary's date of birth? _____
 b. What is the beneficiary's Social Security /Trust Identification/Estate Identification No.? _____
 c. What is the beneficiary's phone number? _____
 d. What is the beneficiary's relationship to the deceased? _____

Remarks: _____

I have not been notified by the Internal Revenue Service that I am subject to back-up withholding as a result of failure to report all interest or dividends. **Cross out this statement if you have been so notified.**

I certify, under penalty of perjury, that the Social Security or Taxpayer Identification Number and Back-up Withholding status information are correct. I further certify that I am a U.S. person, including a U.S. resident alien (non-U.S. person must complete form W-8BEN).

All of the above answers and statements are true and complete, and correctly recorded. I understand that the furnishing of forms by the Company does not constitute an admission that there is any insurance coverage in force or payable.

The policy/certificate IS / IS NOT (circle one) attached. (See Instructions (5) on back)

WARNING: Please see the fraud warnings included with this form. The fraud warning for the state of NY is below. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

 Personal Signature of Witness

 Printed Name of Witness

 Address of Witness

 City, State, ZIP of Witness

 Personal Signature of Claimant

 Printed Name of Claimant

 Address of Claimant

 City, State, ZIP of Claimant

RETURN COMPLETED CLAIM DOCUMENTS TO

**CLAIMS DEPARTMENT
 6400 C STREET SW
 CEDAR RAPIDS IA 52499**