Life Insurance

CLAIMANT STATEMENT

Return this form with:
1. **Insurance Policy or Lost Policy Affidavit**
2. **Certified Death Certificate**

To: PO Box 833879
Richardson TX 75083-3879

- ☐ **Central Security Life Insurance Company**
- ☐ **Western American Life Insurance Company**
- ☐ _____

Ophelia Powell
Name of Deceased

ALOLR037639, ALOLR051101
List all policy numbers with this company

Date of Birth

Date of Death **Place of Death**

From what record was date of birth obtained?

Cause of Death

If any policy with this company was assigned, give particulars:

The undersigned hereby makes claim to said insurance as beneficiary and agrees that the written statements and affidavits of all physicians who attended or treated the insured and all other papers called for by the instructions shall constitute and they are hereby made part of these Proofs of Death, and further agrees that the furnishing of this form or any of the forms supplemental thereto by the Company shall not constitute nor be considered an admission by it that there is any insurance in force on the life in question nor a waiver of any of its rights of defenses.

FRAUD WARNING: Please see the attached Fraud Warning Notices and read the fraud warning notice for your state.

X

Signature of Beneficiary / Heir / Executor / Power of Attorney

Print Claimant Name **Age** **Social Security No** **Relationship to deceased**

Claimant's Mailing Address **Phone Number**

X

Witness Signature (non-family member) **Print Witness Name**

Witness Address (street / city / state / zip) **Date Signed**

Each Claimant Must Complete His/Her Own Form

C-005-2010-06

LOST POLICY AFFIDAVIT - BENEFICIARY

Return To:

PO BOX 833879
RICHARDSON TX 75083-3879

☐ Central Security Life Insurance Company
☐ Western American Life Insurance Company
☐ _____

I, _____, the beneficiary of policy number **ALOLR037639, ALOLR051101** (hereinafter referred to as the "original policy") of the Company on the life of **Ophelia Powell,** do hereby warrant and declare that said policy has been lost or destroyed, that I have no knowledge whatsoever of the present whereabouts of said policy, that there has been no sale, transfer, or assignment of said policy and that no person or persons, other than the undersigned, has any claim, title or interest therein or thereto or to any part thereof whatsoever.

I agree to indemnify and protect the Company against any claim that may be asserted against the Company under said original policy which is alleged to have been lost, destroyed, stolen or wrongfully converted.

The undersigned hereby agrees to notify the Company if said policy ever shall be found or discovered.

Dated at _____ this _____ day of _____, _____.

X _____ **Signature of Beneficiary**

_____ **Social Security Number**

_____ **Beneficiary's Street Address**

_____ **Phone Number**

_____ **City, State, Zip Code**

_____ **Date Signed**

X _____ **Witness Signature (non-family member)**

_____ **Witness Address (street / city / state / zip)**

_____ **Print Witness Name**

_____ **Witness Phone Number**

Each Beneficiary Must Complete His/Her Own Form

Fraud Warning: Please see the attached Fraud Warning Notices and read the fraud warning notice for your state.

X-005 Beneficiary 2010-03