

PROVIDENT AMERICAN INSURANCE COMPANY

10501 North Central Expressway, Suite 200, Dallas, Texas 75231, (214) 696-9091

Policy Number: _____ **Name of Deceased:** _____
Beneficiary name and address: _____

**THIS WILL ACKNOWLEDGE NOTICE OF THE DEATH OF THE NAMED POLICYOWNER.
IT IS NOT NECESSARY TO EMPLOY ANY PERSON OR INCUR ANY
EXPENSE TO COLLECT A VALID CLAIM FROM THIS COMPANY.**

This form must be completed by the party or parties to whom insurance is payable as beneficiary(s). If there is more than one beneficiary, all beneficiaries may sign the same statement. When policy is payable to a minor, claimant's statement must be made by the guardian, a certified copy of whose appointment and authority must be furnished.

When policy is payable to estate or legal representative of the insured, claimant's statement must be made by the executor or administrator, a certified copy of whose appointment and authority must be furnished.

When policy is payable to a corporation or firm, the claimant's statement must be made by a duly qualified officer who has the power and right to make such claim in the name of the corporation or firm.

If any named beneficiary predeceased the insured, unless policy specifically provides otherwise, claimant's statement should be made by the duly appointed executor or administrator of insured's estate, copy of whose appointment and authority should be furnished. Also certified copy of death certificate of deceased beneficiary is required. Two persons must witness each signature.

In addition to the claimant's statement, please furnish:

- 1. Attending Physician's Statement**
- 2. Certified Copy of Death Certificate**
- 3. The Policy**

When a coroner's inquest or investigation has been held, a copy of the evidence and verdict, duly certified, must accompany physician's statement.

If policy has been assigned, it is necessary that an assignment agreement form be completed by the assignee and beneficiary(s).

CLAIMANT'S STATEMENT

Name of Deceased:	Date of Death:
Date of Birth:	Place of Death:
Place of Birth:	When did insured first experience symptoms of last illness/disease?
Cause of Death:	In last illness, when did deceased first consult physician?

**LIST ALL PHYSICIANS WHO ATTENDED OR PRESCRIBED TREATMENT FOR
DECEASED WITHIN THE LAST FIVE YEARS PRECEDING DEATH**

Name and Address	Dates of Attendance	Illness/Disease

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 hereon shall constitute and they are hereby made a 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 was any insurance in force on the life in question nor a waiver of any of its rights or defenses.

I expressly waive on behalf of myself and any other party who shall have or claim any interest in any policy issued to the insured, all provisions of law forbidding any physician or any other person who attended or examined the insured, or any hospital (including Veteran's Hospital) or sanitarium in which insured was confined, treated, or examined, from disclosing any information or knowledge acquired thereby and I authorize the furnishing of all such information to the above named insurance company. A photostat copy of this authorization shall be considered as effective and valid as the original.

Claimant's Signature: _____ **Relationship to Deceased:** _____

Witness to Signature: _____ **Witness to Signature:** _____