PROOF OF DEATH/CLAIMANT STATEMENT
UTG, INC.

P.O. Box 410, Stanford, KY 40484-0410

Universal Guaranty Life (800) 323-0050
* Independent Order of Vikings (877) 241-6006
UG/Genworth Life & Annuity (866) 662-2344
IdeaLife Insurance (866) 579-9432

1. DECEDENT INFORMATION

Deceased's Name in Full

Last First Middle

Deceased's Social Security Number

— —

Deceased's Residence at Time of Death

Number Street City State Zip Code

Date of Birth

/ /

Month/Day/Year

Nature of Death

Natural ☐ Accidental ☐ Suicide ☐ Homicide ☐

If other than Natural describe circumstances and attach any newspaper clippings or reports

Date of Death

/ /

Month/Day/Year

2. POLICY INFORMATION

Policy Number(s) ________________

☐ Check box if policy is lost or unavailable. Please Explain ________________

If the policy is lost, misplaced, destroyed or not submitted, I hereby release and discharge the Company from any and all future claims and demands whatsoever under the original policy. If the original is ever found, it shall be returned to the Company.

The undersigned hereby makes claim to said insurance and understands that the furnishing of forms by the Company does not constitute an admission that there is any insurance in force. I authorize any physician or any other person who attended or examined the Insured or any hospital, (including veterans'), mental and/or drug/physical rehabilitation facility which the Insured was confined, treated or examined to disclose any information acquired thereby and to furnish all such information to the above named Insurance Company and their reinsurers. A photostatic copy of this authorization shall be considered as effective and valid as the original. The statements included herein are true and complete.

The undersigned agrees to indemnify and hold harmless the said Insurance Company from any costs, actions, losses or damages which it may suffer by virtue of payment of any proceeds under the above described policies and agrees to join into any litigation concerning the payment of said proceeds and furnish further proofs, if requested.

If this policy was issued or reinstated in the past two years, we may be conducting a routine claim review in accordance with the incontestability provision in the policy. Although not required when making a claim for life insurance benefits, an Authorization to Disclose Health Information may be needed during the processing of the claim.

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.

☐ **I have not been notified by the Internal Revenue Service that I am subject to a Back-up Withholding order on interest and dividends.**

☐ **I have been notified by the Internal Revenue Service that I am subject to Back-up Withholding order on interest and dividends.**

3. CLAIMANT INFORMATION

Claimant's Name (please print)

Claimant's Social Security Number — —

Date

Age

Claimant's Mailing Address

Number Street City State Zip Code

E-Mail Address

Claimant's Signature

Relationship to Deceased

Claimant Phone No. ( )

Witness Signature (unrelated adult)

Date

Witness Name (please print)

Witness Address

Number Street City State Zip Code