LeadersLife INSURANCE COMPANY

Return to: Bay Bridge Administrators
PO Box 161690
Austin TX 78716
800-845-7519

DEATH BENEFITS CLAIM FORM

(CLAIM FORM MUST BE RETURNED WITH AN ORIGINAL CERTIFIED DEATH CERTIFICATE)

POLICY NUMBER(S)_____ WHO HAS THE POLICY OR POLICIES?_____

FULL NAME OF DECEASED _____ SSN _____

RESIDENCE ADDRESS OF DECEASED _____

CITY:_____ STATE:_____ ZIP:_____

DATE OF BIRTH OF DECEASED ____/____/_____ PLACE OF BIRTH _____

OCCUPATION OF DECEASED _____ DATE LAST WORKED _____/_____/_____

WHEN DID DECEASED FIRST COMPLAIN OR GIVE OTHER INDICATIONS OF LAST ILLNESS?

_____

_____

NAME/ADDRESSES OR PHONE NUMBERS OF ALL PHYSICIANS OR PRACTITIONERS WHO ATTENDED TO THE DECEASED WITHIN FIVE YEARS PRECEDING DEATH:

NAME	ADDRESS	PHONE NUMBER	DATE OF ATTENDANCE	DISEASE/CONDITION

DATE OF DEATH _____ PLACE OF DEATH _____ CAUSE OF DEATH _____

The statements above are true and complete. I/we agree that the Company may rely upon them as part of the proofs of death under the policies numbered above. Any physician or practitioner who has attended _____, Deceased Insured, and/or any hospital (including Veterans Administration Hospital) or other institution in which the Deceased Insured was treated or confined, is hereby authorized to furnish to Leaders Life Insurance Company or its representatives, any and all information and records with respect to any illness or injury, medical history, consultations, prescriptions or treatments pertaining to the Deceased Insured. Such information may be included as part of the proofs of death submitted to the Company. *I further understand that the information authorized for release may indicate the presence of a communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immune deficiency virus, also known as acquired immune deficiency syndrome (AIDS).*

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

SIGNATURE _____ SOCIAL SECUITY NUMBER _____
(BENEFICIARY/NEXT OF KIN)

ADDRESS _____ CITY:_____ STATE:_____ ZIP_____

PHONE _____ DATED AT_____ (CITY & STATE) THIS _____ (DAY) DAY OF_____ (MONTH & YEAR)

**NOTARY **

STATE OF_____)

COUNTY OF_____)

On this _____ day of _____ personally appeared before me the above named

_____who is known to me and who subscribed the foregoing statement before me and made

Oath that the foregoing answers are each and all complete and true.

Notary Signature _____ My Commission Expires_____