LIFE INSURANCE COMPANY OF ALABAMA
P. O. Box 349
Gadsden, Alabama 35902
(256) 543-2022

CLAIMANT'S STATEMENT

Name of Deceased	Policy Number
Date of Birth	Date of Death

If Policy has been in force less than 2 years. Please complete the next 2 sections.

List all Physicians who attended or prescribed treatment for deceased within the last five years preceding death.

Names and Addresses	Dates of Attendance	Disease

List all other life or accident insurance on the life of the deceased.

Companies or Associations	Policies Dated	Amounts of Insurance

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 Veterans' 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 photostatic copy of this authorization shall be considered as effective and valid as the original.

Claimant's Signature ____________________ Age __________ Relationship to Deceased ____________________

Witness to Signature ____________________ Witness to Signature ____________________

Claimant's Signature ____________________ Age __________ Relationship to Deceased ____________________

Witness to Signature ____________________ Witness to Signature ____________________

Beneficiary name and address ____

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Beneficiary Social Security No.____________________

Form No. PH-3316

This will acknowledge notice of the death of the named policyowner.

It is not necessary to employ any person nor incur any expense to collect a valid claim from this company.

The form of claimant's statement is on reverse side of this sheet.

This must be made by the party or parties to whom insurance is payable as beneficiaries. If there is more than one beneficiary, all beneficiaries may sign the same statement, or each beneficiary may make a separate 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.

Each signature must be witnessed by one person.

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

1. Certified Copy of Death Certificate,
2. The Policy or Lost Policy Affidavit

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 or beneficiaries.