



Guide to making your claim

To submit your claim, please follow these steps:

- **Claimant's Statement**
- **HIPAA Compliant Authorization**
- **Next-of-Kin Affidavit**
- **Physician's Statement**

SECTION 1: Claim Submission Instructions

To submit your claim, please follow these steps:

1. Complete the required forms

Fill out the enclosed **Claimant's Statement, HIPAA Authorization, and Next-of-Kin Affidavit** carefully, following the instructions provided on the form. The enclosed Physician's Statement should be completed by the attending physician. Be sure to include all requested information to help us process your claim promptly.

2. Submit Your Documents

Return the completed claim form along with the required documents listed in **Section 4** of the form.

For claims under \$30,000.00, you may email a scanned, legible copy of your documentation to claims@aatx.com.

SECTION 2: What Happens Next

We're committed to reviewing and processing your claim as quickly as possible.

Additional Review Required: As the insured died within the contestability period of the policy a review of medical records to verify the accuracy of the original application answers will be completed as part of the claims review process. The beneficiary may have a duty to cooperate as is reasonably necessary in any investigation including providing necessary authorizations for medical records and other information. We will make every effort to expedite this process.





PO Box 2549, Waco TX 76702-2549 • 254-297-2777 / 800-736-7311 • Email: claims@aatx.com • www.americanamicable.com

CLAIMANT'S STATEMENT

INSTRUCTIONS FOR COMPLETING THIS FORM – Missing or incomplete information may delay claim processing. The paperwork requested below must be received in good order, all questions answered, dated and all necessary signatures and documentation furnished. The Company reserves the right to require or obtain further proof should it be deemed necessary. By furnishing forms and investigating the claim, the company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

- 1. Claimant's Information** – The named beneficiary should complete this form and sign before a witness who should also sign the form. If there is more than one beneficiary, each one must complete a separate form.
 - **If the beneficiary is an Estate**, the form should be completed and signed by the Executor or Administrator of the Estate in his or her capacity as Executor or Administrator. Properly certified letters of administration must be submitted with the completed form.
 - **If the beneficiary is a Trust**, the form should be completed and signed by the Trustee of the Trust in his or her capacity as Trustee.
 - **If the beneficiary is a minor**, the form should be completed and signed by his or her legal appointed guardian in his or her capacity as Guardian. Certified letters of guardianship must be submitted with the completed form. In the event no guardian is to be appointed, contact the Company for further instructions.
- 2. Certified Death Certificate** – Attach a certified death certificate showing cause of death for the insured.
- 3. Policy** – Attach the insurance policy or policies pursuant to which claim is made (or certify that any policy not included is lost by your signature below).

SECTION 1: Information about the deceased

Policy Number		Amounts	
Name of Deceased in Full		Maiden Name	
Residence at Death: Street	City	State	Zip
Date of Birth	Place of Birth		
Date of Death	Place of Death		
Cause of Death			

Marital Status: Single Married Divorced Separated Widow / Widower

Note: Complete question below, if the policy has been in-force for less than 2 years and / or accidental death benefits are claimed.

Date deceased first complained of, or gave other indications of his/her last illness:

When did deceased first consult a physician for his/her last illness?

When did deceased last attend his/her last usual work?

Given names and address of all physicians who attended the deceased during the last five years prior to death

Names	Addresses	Date of Attendance	Disease or Condition

In what other companies, and for what amounts, was the life of the deceased insured under accident and/or life policies?



SECTION 2: Information about you

You are completing this form as: [] Beneficiary [] Executor [] Administrator [] Assignee
[] Guardian [] Other: (Explain) _____

Form with fields: Claimant's Printed Name, Date of Birth, Relationship to Insured, Maiden Name, Country of Citizenship, Male/Female, Social Security Number, Phone Number, Email, Residence: Street, City, State, Zip

SECTION 3: Certification and Signature

By signing this claim form, you certify that:

- The information provided is true and complete to the best of your knowledge.
If an overpayment occurs...you agree to repay the overpaid amount.
You have read and understand the Claim Fraud Warnings included with this form.
Important Notice for New York Residents: Any person who knowingly and with intent to defraud an insurance company...

Under penalties of perjury, I certify that:

- The Social Security number provided in Section 2: Information About You is my correct taxpayer identification number.
I am not subject to backup withholding because:
I am exempt from backup withholding, or
I have not been notified by the IRS that I am subject to backup withholding due to underreporting of interest or dividends, or
The IRS has notified me that I am no longer subject to backup withholding.
I am a U.S. citizen, resident alien, or other U.S. person.*
I am not subject to FATCA reporting because I am a U.S. person* and the account is located within the United States.

Note: If the IRS has notified you that you are currently subject to backup withholding due to underreporting, please cross out Item 2 above.

* If you are not a U.S. citizen, resident alien, or other U.S. person for tax purposes, please cross out Items 3 and 4 above and submit Form W-8BEN (for individuals) or Form W-8BEN-E (for entities).

[] Under penalties of perjury, I certify that I am a Non-Resident Alien and my country of residence is:

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signature of the person making the claim, Date Signed, Witness Signature, Date Signed



SECTION 4: Submitting Your Documents

4A. Check off the items you're sending with your Claimant's Statement

DEATH CERTIFICATE

Include a copy of the death certificate.

- For claims over **\$30,000**, a **certified** death certificate is required. Certified copies typically have a raised or colored seal and can be obtained through the funeral director handling the arrangements.
- **Only one death certificate is needed.** If another claimant is submitting one, you do not need to send a duplicate.

HIPAA COMPLIANT AUTHORIZATION

HIPAA Compliant Authorization must be completed and signed by the immediate next of kin on the death certificate.

NEXT-OF-KIN AFFIDAVIT

Next-of-Kin Affidavit must be completed by the immediate Next-of-Kin who signs the HIPAA authorization with signature notarized with a visible seal. Please send a copy of the legal Next-of-Kin's state issued Identification Card or Driver's License (front and back).

PHYSICIAN'S STATEMENT

Physician's Statement must be completed by insured's family or primary physician (or provide the name, address and telephone number).

POLICY NUMBERS

List the policy numbers you are filing a claim for in **Section 1**.

FUNERAL HOME AUTHORIZATION

If you signed a document authorizing **payment directly to a funeral home**, please include a copy of that agreement.

ACCIDENTAL DEATH DOCUMENTATION

If the claim involves accidental death, include supporting documentation such as police reports or other relevant records.

POWER OF ATTORNEY

If you are **acting as Power of Attorney** for the beneficiary, include a copy of the legal appointment papers.

EXECUTOR OF ESTATE

If the beneficiary is the Insured's or the Beneficiary's Estate, the Executor of the **appropriate** Estate must sign the Claimant's statement and provide a copy of the certified court document showing their appointment. If no Estate will be set up, contact the Company for further instructions.

OTHER:

4B. Please mail your completed claim to the following address:

Mail forms to:

P.O. Box 2549
Waco, TX 76702-2549

For claims under \$30,000.00, you may:

Email to: claims@aatx.com or Fax to: 1-254-297-2756.

STATE FRAUD WARNING NOTICES

For your protection, the laws of several states (including those listed below) require that we provide you with the following statements. **General Fraud Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Alabama Fraud Warning:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska Fraud Warning:

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona Fraud Warning:

FOR YOUR PROTECTION ARIZONA LAW REQUIRES THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Arkansas, District of Columbia, Louisiana, Maryland, New Mexico, Rhode Island and West Virginia Fraud Warning:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California Fraud Warning:

For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Fraud Warning:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware and Idaho Fraud Warning:

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement or claim containing false, incomplete or misleading information is guilty of a felony.

Florida Fraud Warning:

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

Hawaii Fraud Warning:

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Indiana Fraud Warning:

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas Fraud Warning:

Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Kentucky Fraud Warning:

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington Fraud Warning:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota Fraud Warning:

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire Fraud Warning:

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New Jersey Fraud Warning:

Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties.

Ohio Fraud Warning:

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.

Oklahoma Fraud 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.

Oregon Fraud Warning:

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Pennsylvania Fraud Warning:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information containing any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico Fraud Warning:

Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas Fraud Warning:

For your protection Texas law requires the following to appear on this form:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont Fraud Warning:

Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.



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GROUP**

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS
IA AMERICAN LIFE INSURANCE COMPANY
INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.
OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
PIONEER AMERICAN INSURANCE COMPANY
PIONEER SECURITY LIFE INSURANCE COMPANY

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Insured: _____

Policy No: _____

Date of birth: _____

SSN: _____

Date of death: _____

HIPAA Compliant Authorization to Release Confidential Medical Information

Upon presentation of the original or a photocopy of this signed authorization, I authorize any physician or other medical professional, hospital or other medical care institution, laboratory, insurance support organization, pharmacy, governmental agency, health plan, insurance company, group policyholder, employer, benefit plan administrator, or other party in possession of medical records pertaining to the patient, employee, or deceased named above, to provide _____ (hereafter referred to as "the Company"), its agents, employees, and representatives, or any medical records retrieval service the Company may engage, including, but not limited to, Mediflash, or any agent, attorney, consumer reporting agency, or independent administrator, acting on their behalf, the entire medical record and any other protected health information concerning the patient, employee, or deceased named above, including, but not limited to, information relating to: mental illness (excluding psychotherapy notes), communicable or infectious conditions (such as HIV, AIDS, and sexually transmitted diseases) the use of prescription drugs, the use of tobacco, alcohol abuse, or drug abuse.

I also authorize my or his/her employer, group policyholder or benefit plan administrator to provide the Company with financial or employment related information.

I understand that such information will be used by the Company for the purpose of evaluating my claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure and may no longer be covered by the rules governing privacy and confidentiality of health information that applied in the first instance. This authorization is valid for two years from the date signed. A copy of this authorization is as valid as the original.

I understand that I may revoke this authorization at any time by sending a written request for revocation to the Company at its address indicated above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. I understand that if I refuse to sign this authorization the Company may be unable to honor my claim for insurance benefits.

X	X	X
Signature of Authorized Representative or Next of Kin	Relationship	Date

X
Printed Name of Authorized Representative or Next of Kin

X	X
Signature of Witness	Address of Witness

AFFIDAVIT OF SURVIVING SPOUSE OR NEXT OF KIN

VENUE

_____)
(State))
)
_____)
(County)

SS:

1. _____, being duly sworn according to law, declare
(First, middle, last or maiden name)

that I reside at _____, _____ and that on
(Street address) (City and state)

_____, _____, had permanent
(Mo., day, year of death) (Name of deceased)

legal residence at _____.
(Complete address of decedent)

I am the widow, child, father, mother, brother, sister, other _____,
(Circle appropriate relationship) (Specify if other)

and as such am entitled to receive the decedent's estate under the laws of

(Name of state in the United States where decedent last had legal permanent residence)

NAME(S) OF SURVIVORS, IN ORDER OF KINSHIP

Please insert the names of living relatives in the following order of relationship:
surviving spouse, children, father, and /or mother, brothers and/or sisters:

<u>Name</u>	<u>Date /Place of Birth</u>	<u>Address</u>	<u>Relationship</u>
1. _____ _____	_____	_____	_____
2. _____ _____	_____	_____	_____
3. _____ _____	_____	_____	_____
4. _____ _____	_____	_____	_____
5. _____ _____	_____	_____	_____
6. _____ _____	_____	_____	_____

The estate is not now nor will it be administered

(Signature of Affiant)

Subscribed and sworn (or affirmed) to before me by _____
(Typed name of affiant)

at _____ on _____
(Address of Notary of Public) (Date)

(Seal)

(Signature of Notary Public)

(Typed name of Notary Public)



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PHYSICIAN'S STATEMENT

This statement is to be furnished without expense to the Company

1. (a) Deceased's name in full Date of Birth Age at Death
(b) Residence at death Occupation

2. Sex How long have you know the deceased?

3. (a) Date of death Place of death
(b) If death occurred in hospital please give name and address

(c) When were you first consulted for the condition which directly or indirectly caused death?

4. (a) What was the immediate cause of death? Does this agree with Death Certificate?
(b) How long in your opinion did this disease or impairment exist?
(c) What was the date of onset of the first symptom or sign according to the clinical history?

5. (a) Contributory cause of death Duration
(b) Other chronic diseases or impairments Duration

6. (a) If death was due to suicide, homicide or accident, state which Please describe briefly
(b) Was an official inquiry held? Was a post-mortem examination made? If so, please give particulars

Table with 4 columns: Disease or Condition, Date, Duration, Result

8. Please give names and addresses of all other physicians or other practitioners who attended deceased within the five years preceding death. Name Address Disease or Impairment

I hereby certify that the above facts are true and complete to the best of my knowledge.

Physician's printed name Signature, M.D. Address Street and Number

Date 20 City State