S.USA Life Insurance Company, Inc.
P.O. Box 2549
Waco, Texas 76702

1-800-746-1670
Visit us at www.susa-waco.com
E-mail: cx@susa-waco.com

Policy administration services provided by American Amicable Life Insurance Company of Texas.

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.

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CLAIMANT'S STATEMENT

Instructions for Completing this Form

1. Claimant's Information

a. This form should be completed in full detail by the named beneficiary before a witness who should sign the form. If there is more than one beneficiary, each one should complete a separate form.

b. If the beneficiary is an Estate, the form should be completed by the Executor or Administrator of the Estate and should be forwarded to the Company accompanied by the properly certified letters of administration. Where a beneficiary signature is required, it shall be understood that the individual signing is signing in his or her capacity as the Executor or Administrator of the Estate.

c. If the beneficiary is a Trust, the form should be completed by the Trustee of the Trust. Where a beneficiary signature is required, it shall be understood that the individual signing is signing in his or her capacity as the Trustee of the Trust.

d. If the beneficiary is a minor, claim for the benefit should be made by his or her legal appointed guardian and certified letters of guardianship should be furnished. Where a beneficiary signature is required, it shall be understood that the individual signing is signing in his or her capacity as the Guardian of the minor beneficiary. In the event no guardian is to be appointed, contact S.USA Life for further instructions.

2. Certified Death Certificate – A certified death certificate with cause of death for the insured should be provided.

3. Policy – The insurance policy or policies should be forwarded with the claim papers.

1. (a) NAME OF DECEASED IN FULL:

(b) Indicate other names by which the insured may have been known, such as maiden name, hyphenated name, nickname, derivative form and/or middle name or an alias

2. Policy(s) or Certificate(s) of S.USA Life Insurance Company, Inc., under which claim is made:

Policy or Certificate No. Amount

3. Is the Accidental Death Benefit rider a part of this policy or certificate? Yes _____ No _____
If "Yes", is ADB being claimed? Yes _____ No _____If "Yes", please describe accident:

4. (a) Date of Death:

(b) Place of death (address, or if hospital, its name and address.):

5. Cause of death (if due to suicide, so state):
Please give particulars.

6. Last residence of deceased:

7. (a) Date of deceased's birth:

(b) Place of birth:

8. When did deceased first complain of, or give other indication of, last illness?

9. Give name and address of every hospital, physician or other practitioner who attended deceased during five years prior to death:
Name Address Date Disease or condition

10. Name and address of deceased's last employer:

11. Last occupation of deceased:

12. Name of every other bank and company insuring the life of deceased at the time of death:

13. Do you claim these proceeds as:

☐ Beneficiary ☐ Executor ☐ Administrator ☐ Trustee ☐ Assignee ☐ Guardian ☐ Other: (explain) _____

14.(a) What is your date of birth?	(b) ☐ Male ☐ Female	15. Your home telephone No.: Business telephone No.:

16. Taxpayer Identification Number or Social security Number:

Under the penalties of perjury by signing below, I certify that:

(a) The Taxpayer ID Number or Social Security Number above is my correct number (or I am waiting for a number to be issued to me); and

(b) I have not been notified by the Internal Revenue Service that I am subject to a back-up withholding order on interest and dividends (if you have been so notified, cross out this entire statement) and

(c) I am a U.S. person (including a U.S. resident alien).

Acknowledgment and Certifications

I hereby certify that the answers I have made to the above questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the attached State Fraud Warning Notices.

New York Residents:

Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or 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 and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of claim for each such violation.

_____ _____

(Date) Claimant's Signature

Print name of Claimant _____

Claimant's Address _____

(Number and Street) (City) (State) (Zip Code)

Name of Insured _____ Policy/Certificate No. _____

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SECTION 3: Submitting Your Documents

3A. 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:**

_____

3B. 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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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 S.USA Life Insurance Company, Inc. (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))
) SS:
_____)
(County)

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:

Name	Date /Place of Birth	Address	Relationship
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)

_____
(Signature of Notary Public)

(Seal)

_____
(Typed name of Notary Public)

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PHYSICIAN'S STATEMENT

This statement is part of an application for benefits under an S.USA Life Insurance Company, Inc., policy or certificate. It is to be completed by the family physician or physician in attendance during the last illness. The beneficiary is responsible for the completion of this form without expense to the Company.

To: _____
(Print Doctor's Name)

1. Name of Deceased Patient:	2. Date of Death:	3. Date of Birth:
4. Cause of Death: (State diagnosis) Due to: ☐ Illness ☐ Accident ☐ Homicide ☐ Suicide ☐ Undetermined Was an autopsy performed? ☐ Yes ☐ No		5. Place of Death: (Address or Name of Hospital)

6. How long did patient suffer from the disease, condition, or injury which caused death?

7. What other diseases or conditions contributed to the cause of death?

8. Date you first diagnosed the conditions contributing to death: Month _____ Day _____ Year _____
Was the patient aware of your diagnosis? ☐ Yes ☐ No If yes, date informed: Mo. Day Yr.

PATIENT HISTORY

9. Date you first treated the patient: Month _____ Day _____ Year _____

10. Who referred this patient to you? (State name and address:) ☐ Doctor ☐ Hospital ☐ Clinic ☐ Family ☐ Other:

11. Name of each hospital where the patient was confined or treated in the last 5 years: (State dates admitted and discharged, with diagnosis, if known)

12. Name and address of patient's regular personal physician:

13. Name and address of other physicians in attendance during the last illness?

14. State diagnoses of any other conditions or diseases the patient was treated for within the last 5 years:

15. If any surgery was performed in the last 5 years, state date and type of surgery:

16. Did the patient use tobacco in any form? ☐ Yes ☐ No If yes, what type and for how long?

Telephone Number

Date _____ Signature of Physician _____(_____)_____

Address _____
(Number and Street) (City) (State) (Zip Code)