Fidelity Life Association
Administrative Office:
One Integrity Parkway
Cleveland, OH 44143

Claim Form – Life Insurance Plan

IMPORTANT: "Statement of Claimant" must be completed in all cases. If there are two or more beneficiaries or other claimants, each beneficiary must complete a "Statement of Claimant". Each beneficiary must make a separate statement.

Statement of Claimant

POLICY NUMBER(S): _____

1. Decedent Information – *(Please print in ink or type)*

Name	First	Middle	Last	
Residence at time of death	Street	City	State	ZIP
Date of Birth		Place of Death		
Date of Death		Cause of Death	Manner of Death	

2. Beneficiary or Claimant Information

Name	First	Middle	Last	
Residence	Street	City	State	ZIP
Date of Birth		Day Time Telephone	Relationship to Deceased	

_____ -- _____ -- _____

Beneficiary/Claimant Social Security Number

Are you subject to back-up withholding? (Has the IRS contacted you directly to inform you that you are subject to back-up withholding?) ☐ Yes ☐ No

In what capacity or title do you Claim this Insurance? Check one:

☐ Beneficiary ☐ Assignee ☐ Trustee ☐ Executor/Administrator ☐ Guardian ☐ Other

3. Statement of Lost Policy *(Complete only if policy is unavailable for return)*

☐ I am unable to locate the original life insurance policy. I agree to return the policy to The Company if found.

4. Payment of Fund – *Please Select One*

☐ Single Sum Payment
(If the proceeds are to be paid as one settlement, payment will be made under the Fidelity Life Immediate Convenience Account, if eligible.)

☐ Installment Payments *(Please refer to the certificate for options. If certificate is not available, please contact our office.)*

Installment Option Elected: _____

Payment Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

5. Signatures

The undersigned hereby makes claim to said insurance (or contractual portion thereof, if more than one claimant) and 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.

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 subjects such person to criminal and civil penalties.

Notice to California Residents

For your protection, California 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.

Information Authorization

Any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge about the insured is hereby authorized to disclose any such information. A photographic copy of this authorization shall be as valid as the original. (This information will only be obtained for contestable claims.)

"Under the penalties of perjury, I certify that the information supplied on this form is true, correct and complete."

Claimant Signature	Date	Agent Signature	Date
Please Print Name		Please Print Name	
		Agent Number	

Notary

State of _____

County of _____ **} SS.**

Date: _____, personally appeared before me at _____,

State of _____, the above Claimant, who is known to me and who subscribed the foregoing statement before me and stated under oath that the statements and answers above made and subscribed are true and full.

In Witness Whereof, I have hereunto subscribed my name and affixed my official seal.

(Seal)

My Commission Expires: _____

Notary Public _____