USA LIFE ONE Insurance Company of Indiana

"Insuring Your Interest Since 1894"

Life Insurance Claim Form

To file a claim under this policy, please return the following:

1. This form filled out completely (Front Only_____ Front and Back_____)
2. The policy or policies
3. The certified death certificate
4. **Mail paperwork to USA Life One, P O Box 609, Fishers IN 46038**

INSURANCE FRAUD WARNING:

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

Insured's Name:_____

Policy Number(s)_____ _____ _____ _____ _____

Date of Birth:_____ Date of Death:_____

Cause of Death: _____

Information of Beneficiary(ies) -- please print

Name and Address	Social Security Number	Date of Birth

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that in furnishing this form, the Company does not acknowledge liability or waive any rights or defense. All beneficiaries must sign below:

1) _____

2) _____

3) _____

Witness:_____ Date:_____

In Order That We May Promptly Process This Claim:

Furnish name and address of physician or facilities attending the deceased at the time of death, and five years prior to death and why:

Name and Address	Dates/Reasons	Phone Number

Furnish names of other insurance companies on which a claim will be made:

Name of Other Insurance Company	Date of Issue

Authorization to Release Information (Please read and sign)

I authorize the USA Insurance Company of Indiana or its reinsurer(s) to obtain medical and other information on the Insured. This includes information about drugs and alcohol and about diagnosis, treatment and prognosis of any physical or mental condition, as well as any other non-medical information.

This information can be released by doctors including medical practitioners and pharmacists. It can also be released by any hospital, clinic or other medical or medically related facility, including facilities run by the Veteran's Administration. Information can also be released by insurers, reinsurer(s), the Medical Information Bureau (MIB, Inc), employers, schools and consumer reporting agencies.

I also authorize all the above sources (except MIB, Inc) to give such records or information to any consumer reporting agencies employed by USA Life One Insurance Company of Indiana to collect and transmit such information.

I acknowledge that the information obtained by this authorization will be used by USA Life One Insurance Company of Indiana to evaluate a claim for insurance benefits. Any information obtained will only be released by USA Life One Insurance Company of Indiana to reinsurer(s), or other persons or organizations performing business or legal services in connection with my claim. The information may also be released if USA Life One Insurance Company of Indiana is required to do so by law, or if I authorize its release.

This authorization will be valid from the date signed and for the duration of the claim. I understand that is am entitled to receive a copy of this authorization upon written request.

Signature of Beneficiary, Parent or Legal Guardian

Witness

Date