



COTTON STATES LIFE INSURANCE COMPANY
 244 Perimeter Center Parkway N.E. Atlanta, Georgia 30346
 Mailing Address: P.O. Box 105303 Atlanta, Georgia 30348
 Toll Free: 1-800-457-1657

CLAIMANT'S STATEMENT

INSTRUCTIONS

- I. This form must be completed by the beneficiary named in the policy, unless otherwise specified in Section II. If there is more than one beneficiary, all beneficiaries can sign the same statement, or each beneficiary can complete a separate statement.
- II. If the beneficiary named in the policy is a:
 - A. **Minor**, the claimant's statement must be completed by the guardian. A certified copy of letters of guardianship must be submitted.
 - B. **Executor or Administrator**, the claimant's statement must be completed by the executor or administrator of the estate of the insured. A certified copy of letters testamentary or letter of administration must be submitted.
 - C. **Corporation or Firm**, the claimant's statement must be completed by a duly qualified officer who has the power and right to make such claim in the name of the corporation or firm.
 - D. **Predeceased Beneficiary**, a certified copy of the death certificate of the deceased beneficiary must be submitted.
- III. Any payment approved by the Company will be made in a lump sum unless otherwise requested.

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE BACK OF THIS FORM.

1. Name of Deceased _____ Policy Number _____

2. Date of Birth _____ Place of Birth _____ Source From Which Date of Birth Obtained _____

3. Date of Death _____ Place of Death _____ Cause of Death _____

4. When did deceased first consult physician for condition resulting in death? _____

5. If death was due to an accident, give circumstances of death. _____

6. List All Physicians Who Attended Deceased Within The Last Five Years: (Not applicable if death was due to an accident.)

Name	Address	Dates of Visits	Diagnosis

7. List All Other Life Insurance In Force On The Deceased:

Company Name	Policy Date	Amount of Insurance

FAIR CREDIT REPORTING ACT - PRE-NOTIFICATION FORM

Public Law 91-508 requires that we advise you that an investigative consumer report may be made in connection with this claim which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through personal interviews with friends, neighbors and associates. Upon written request a complete and accurate disclosure of the "nature and scope" of the report if one is made will be provided.

AUTHORIZATION

I hereby certify that these answers are true and correct to the best of my knowledge. I understand that the completion of this form will not be construed as an admission by the Company of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract. I agree that any physician's statements, affidavits, or additional papers required by the Company will be made a part of this claim.

I authorize any medical professional, medical care institution, insurance institution, consumer reporting agency or similar institution, governmental agency including but not limited to the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or other organization having records or knowledge of me or any member of my family, to release to Cotton States Life Insurance Company, or its reinsurers, any and all such information it may require in the investigation of this claim. I certify that I have received notification regarding the Fair Credit Reporting Act, and understand that I may request a personal interview by a consumer reporting agency. I hereby waive all rights of confidentiality under state and federal credit privacy laws and release from liability the user as well as the person or firm providing such information.

A photocopy of this authorization will be considered as effective and valid as the original.

Claimant's Signature _____ Relationship to Deceased _____ Beneficiary's Social Security # _____ Date _____

Witness _____ Date _____ Witness _____ Date _____

Claimant's Signature _____ Relationship to Deceased _____ Beneficiary's Social Security # _____ Date _____

Witness _____ Date _____ Witness _____ Date _____