Proof of Death

(For Life Policies Only)
Submitted To
American Republic Insurance Company

The furnishing of this form and investigation of the claim is not to be construed as an admission of the validity of any claim or as a waiver of any condition of the policy by the Company.

Instructions For Furnishing Proof of Death

1. Complete **Parts I, II and IV**. If the policy has been in force less than two years or has lapsed within two years from the date of death, you must also complete **Part III.**

2. Enclose a certified copy of the Insured's Certificate of Death that includes the cause and manner of death.

3. If any primary beneficiary has died before the Insured, enclose proof of the beneficiary's death: a copy of the beneficiary's death certificate or obituary or a copy of the Insured's obituary if it mentions the beneficiary predeceased the Insured. In such case, the claim should be made by the other beneficiary(ies), or if there are none, by the duly appointed Personal Representative (Executor or Administrator) of the Insured's estate.

4. If the claim is made on behalf of the Insured's estate, enclose a certified copy of the Letters of Administration or the Letters Testamentary, whichever is applicable, and a completed W-9 for the estate. If the Insured's estate will not be probated and the Insured's state of residence permits payment by affidavit in small estates, enclose the completed affidavit. (The affidavit form can be requested from our office.)

5. If any beneficiary is a minor or legally incompetent, enclose a certified copy of the Letters of Guardianship or the Letters of Conservatorship, whichever is applicable.

6. If there is a claim for accidental death benefits, furnishing a newspaper account, police report, or coroner's verdict can facilitate the claim.

Mail the completed Proof of Death form and all other necessary documents to:

American Republic Insurance Company
Attention: Life Claims
P O Box 9371
Des Moines, IA 50334-0001

Claimant's Statement

(Please Print All Information)

PART I – The Deceased

Full Name ____
First Middle Last

Residence Address ____
Street City State Zip

Date of Birth ____________________ Date of Death ____________________
Month Date Year Month Date Year

Cause of Death ____

PART II – Beneficiaries

Additional beneficiaries can be listed on the back of this form.

Name ______________________________ Relationship to Insured ____________
First Middle Last

Name ______________________________ Relationship to Insured ____________
First Middle Last

Name ______________________________ Relationship to Insured ____________
First Middle Last

Each beneficiary must complete a W-9 Request for Taxpayer Identification Number and Certification form. The W-9s should be returned with this Proof of Death form. A W-9 form is enclosed. If more forms are needed, copy the W-9 form so each beneficiary has one.

Part III – Medical Care

Complete this part ONLY if the policy is less than two years old or has lapsed within two years from the date of death.

List the names and addresses of all physicians who attended the deceased and all hospitals and institutions where he/she was treated during the last illness and during five years prior to his/her death. If you need more room for this information, please attach a separate sheet of paper.

Physician/Facility Name	Address	Treatment Date	Disease Or Condition
____________	____________ Street ____________ City State Zip	____________ Month Date Year	____________ ____________
____________	____________ Street ____________ City State Zip	____________ Month Date Year	____________ ____________
____________	____________ Street ____________ City State Zip	____________ Month Date Year	____________ ____________

Part IV – Signature and Authorization

These statements are true and complete to the best of my knowledge and belief. I understand that the furnishing of forms by the Company does not constitute an admission that there is any insurance in force.

I authorize every doctor or practitioner who examined or attended ______________________________, deceased, and every hospital or any other institution in which the deceased received treatment to fully disclose to the Company or its duly authorized representative any knowledge or information thereby acquired.

Date _____________________________________ , 20 ________

Signature of claimant or beneficiary – **PLEASE NOTE: Signature must be notarized.**

Printed Name ____

Signature ____

STATE OF ______________________________)
) ss
COUNTY OF ______________________________)

On this the __________ day of ____________________, 20 _____, before me, the undersigned Notary Public, personally appeared ____

known to me to be the person(s) described in and who executed the foregoing instrument, and acknowledged to me that he/she/they signed and sealed said instrument as his/her/their free and voluntary act and deed for the uses and purposes therein mentioned.

IN WITNESS WHEREOF I have hereunto set my hand and affirmed my official the day and year first above written.

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Notary Public in and for the state of _________________________

Residing at ____

My commission expires: ____________________________