Proofs of Death Submitted to:

AMERICAN INCOME LIFE INSURANCE COMPANY

PO BOX 2500 • Waco, TX 76797
Phone - (254) 761-6400 Fax - (254) 741-5705
www.ailife.com

For your protection, laws in certain jurisdictions require the following to appear on this form.

Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 and subjects such person to criminal and civil penalties.

INSTRUCTIONS FOR SUBMITTING A LIFE CLAIM

1) Complete as Follows: Part A and C by the Beneficiary for all claims.
Part B by the Beneficiary - To be completed only if policy is less than 2 years old.
Part D by the Physician - To be completed only if policy is less than 2 years old.
2) To expedite Payment, all questions must be answered fully and accurately.
3) Send this completed form, along with a Certified Death Certificate, and Obituary (if available) to the above address.

Part A - To be Completed by Beneficiary

Policy Numbers

Deceased's Name	Deceased's Date of Birth	Deceased's Gender ☐ Male ☐ Female
Deceased's Address	Did Death Result From: ☐ Suicide ☐ Homicide ☐ Accident If yes to any, please include all Accident/Police Reports and Newspaper Articles	

Date of Death	Place of Death (if Hospital, Give Name)	Cause of Death

Beneficiary's Name	Beneficiary's Relationship to Insured
Beneficiary's Address	Beneficiary's Telephone Number
	Beneficiary's Social Security Number
Beneficiary's Email Address	Beneficiary's Date of Birth

Part B - To be Completed by Beneficiary

COMPLETE ONLY IF POLICY IS LESS THAN 2 YEARS OLD

Give the names and addresses of all physicians who treated the deceased during the 5 years prior to death:

Name	Address	Disease or Condition	Dates

When did Deceased first complain, or give other indication of illness?	When did Deceased first consult a Physician for last illness?

Part C - To be Completed by Beneficiary

AMERICAN INCOME LIFE INSURANCE COMPANY

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Authorization for Release of Health-Related Information
This authorization complies with the HIPAA Privacy Rule

(Print full name of patient and birth date)

Insured's Name _____ Insured's DOB _____ Insured's Social Security Number _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, Medical Information Bureau (MIB), or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the American Income Life Insurance Company (AIL) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco; but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that AIL may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with AIL.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to AIL, Attention: Claims Department, at the above address. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that AIL has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, AIL may not be able to process my claim or make any benefit payments. I have received a copy of this authorization.

_____ _____

Signature of Patient/Beneficiary/Guardian or Personal Representative Date

_____

Personal Representative's Authority or Relationship to Patient, if patient under 18 years old

Please make a copy of this authorization and retain for your records.