INVESTORS HERITAGE *Life Insurance Company*

200 Capital Avenue • P.O. Box 717
FRANKFORT, KENTUCKY 40602-0717
(800) 422-2011 Fax: (502) 223-6575

Reset Form

CLAIMANT'S STATEMENT

SECTION A - COMPLETE FOR ALL CLAIMS

1. Deceased's Last Name First Name Middle Name		7a. Policy(ies) with this Company under which you claim an interest			
		Policy Number	Amount	Policy Number	Amount
2. Date of Birth	3. Source from which date of birth obtained (*Example:* Birth Certificate, Drivers License or Family Bible)				
4. Date of Death	5. Cause of Death				
	6. Social Security No:	7b. Policy Proceeds assigned to: (copy of assignment required)			

8a. Claimant's Name	8b. Claimant's Name
Date of Birth Age Relationship to Deceased	Date of Birth Age Relationship to Deceased
1ST Claimant's Address	2ND Claimant's Address
Claimant's Phone:	Claimant's Phone:

SECTION B
COMPLETE FOR ALL CLAIMS WHEN DATE OF DEATH OCCURS WITHIN FIRST 2 YEARS OF POLICY

1. Date deceased's health was first affected by last illness	2. Date deceased first consulted a physician for last illness	3. date deceased last attended usual work

4. Occupation at Death	5. Name of last employer

6. List physicians/hospitals where treated last 5 years. (Please Use A Sparate Sheet Of Paper If Additional Space Required.)

Name	Address	Date	Disease or Condition

7. If death was violent or accidental, use separate sheet of paper to describe circumstances. Attach newspaper account if Available.

8. In what other companies was the deceased insured for life insurance?

Name of Company	Date of Issue	Amount	Name of Company	Date of Issue	Amount

SECTION C — CERTIFICATION OF CLAIMANT

I/we hereby make claim to said insurance, declare that all answers as above recorded are complete and true, and agree that the furnishing of this and any supplemental forms by the Company, shall not constitute 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, with intent to defraud or knowing that he is facilitating a fraud against an Insurer, submits an application or files a claim containing a false or deceptive statement is guilty of Insurance fraud.**

Claimant's Signature Social Security # Date Witness

Claimant's Signature Social Security # Date Witness

If you do not provide your social security number, we are required to withhold 28% of the taxable proceeds on all Life Insurance Products and 10% of the proceeds on all Annuities.

Reset

NEXT OF KIN/PERSONAL REPRESENTATIVE
RELEASE, SUBROGATION AND ASSIGNMENT FORM
LIFE POLICIES

Funeral Home Responsible for Ensuring All Blanks are Filled In
(must be signed by Next of Kin/Personal Representative when funeral arrangements are made)

Name of Decedent (Insured): _____ Name of Funeral Home: _____

Name of Next of Kin or Personal Representative: _____ Phone Numbers – Cell: _____
(referred to as "Releasor" in this Release, Subrogation and Assignment) Home: _____

Address: _____ Work: _____
STREET CITY STATE ZIP-CODE

Email addresses (if known): _____

Death Benefit Amount: If Investors Heritage Life Insurance Company ("Company") determines the Funeral Home has a valid claim in accordance with the Liquidation Plan, the amount of the claim paid to the Funeral Home is the Death Benefit Amount.

Company assumed the obligations of the Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association ("Association") in the "Assumption Agreement" which was approved by order of the court on June 22, 2011. Company will process and pay death claims in accordance with the Liquidation Plan as required by the Assumption Agreement and court order. The Association fulfills its responsibilities with respect to Memorial Service Life Insurance Company ("Insurer") policyholders under the Assumption Agreement as permitted by 463.253 of the Texas Insurance Code.

Releasor understands that Funeral Home will submit a claim to the Company for payment of the Death Benefit Amount related to the life insurance policy or policies allegedly issued by Insurer insuring the life of Decedent ("Policies") pursuant to the Liquidation Plan that was approved by the 250th District Court of Travis County, Texas on September 22, 2008. The claim is payable only if certain conditions set forth in the Liquidation Plan are satisfied. If and only if Funeral Home's claim for benefits is approved in whole or in part and any Death Benefit Amount is paid by Company to the Funeral Home, the Release, Subrogation, Transfer, and Assignment provisions of this document shall become effective. If the Funeral Home's claim is denied, then Company will not pay a Death Benefit Amount to the Funeral Home. Releasor is being requested to sign this document in advance of Company's determination on Funeral Home's claims in order to avoid the necessity of Releasor executing additional documents at a later date.

The Release and Subrogation, Transfer and Assignment provisions become effective if and only if Company pays a Death Benefit Amount to the Funeral Home.

Release. In consideration of the provision of coverage and payment of the Death Benefit Amount by the Company and other good and valuable consideration, Releasor and Releasor's heirs (if any), personal representatives, guardians, assigns, successors, agents, and all other persons claiming by or through Releasor do hereby release and discharge the Association, the Company, their members, affiliates, agents, attorneys, employees, successors and assigns (collectively the "Association and Related Parties") of and from any and all actions, causes of action, claims, demands, costs, expenses, compensation and any and all consequential or special damage or other damage, past, present or future, whether known or unknown, on account of or in any way arising out of any life insurance policies issued by Insurer which covered the life of Decedent ("Policies"). This release is not intended in any way to release or discharge any person or entity other than the Association, the Company and Related Parties as set forth herein.

Subrogation, Transfer and Assignment. In further consideration of the provision of coverage set forth herein, up to the Death Benefit Amount, Releasor hereby sells, transfers and assigns any and all of Releasor's past, present and future claims, rights, demands, actions and causes of action ("Claims") against the Insurer to the Association which shall be subrogated to all of Releasor's rights under the Policies and which may bring any action or suit for the recovery of any damages or losses sustained by Releasor as deemed best or appropriate by the Association in its sole and absolute discretion.

Further, up to the Death Benefit Amount, Releasor hereby sells, transfers and assigns to the Association any and all past, present and future claims, demands, actions, rights and/or causes of action Releasor may have against the Insurer and any other persons or entities related in any way to the Policies and/or any losses arising under, resulting from, or otherwise relating to the Policies and the Association shall have full power and authority for its own use and benefit, at no cost to Releasor, to ask, demand, collect, prosecute, dismiss or settle any suit or proceedings at law or in equity against the Insurer or any other persons or entities in Releasor's name. Releasor further agrees to cooperate with the Association in its prosecution of any suits or proceedings against the Insurer and all other persons or entities, and will voluntarily testify on behalf of the Association if asked.

The provisions of this Release, Subrogation, and Assignment will inure to the benefit of any successor to the Association pursuant to a Texas law creating a successor to the Association, and to any party to whom the Association assigns its Claims regarding Insurer. The Assumption Agreement and court order do not assign the Association's Claims against Insurer to Company.

Releasor has carefully read the foregoing Release, Subrogation and Assignment and knows the contents and has signed this Release, Subrogation and Assignment voluntarily and with full knowledge of its contents.

The undersigned is legally authorized to sign this Release, Subrogation and Assignment and bind Releasor. Releasor represents and warrants that Releasor is the personal representative and/or next of kin and is authorized to bind the Decedent's estate and any other relatives, heirs, devisees, legatees or successors of the Decedent in connection with any interest any of them my claim in or arising out of the Policies.

Next of Kin or Personal Representative of Decedent/Insured:

Name: _____ Date: _____

Signature _____ Relationship to Decedent/Insured: _____

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize any health plan, physician, health care professional, hospital, Veterans Administration, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, insurance company, insurance support organization such as MIB), or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (collectively, "My Providers") to disclose my entire medical record, medication history, and any other protected health information concerning me to **Investors Heritage Life Insurance Company, or its designee,**

This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STDs.) 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 My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that **Investors Heritage Life Insurance Company** may: (1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; (2) obtain reinsurance; (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (4) administer coverage; and (5) conduct other legally permissible activities that relate to any coverage I have or have applied for with **Investors Heritage Life Insurance Company**.

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 Investors Heritage Life Insurance Company, P.O. Box 717, Frankfort, KY 40602, Attn: General Counsel. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization or to the extent that **Investors Heritage Life Insurance Company** has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal rules governing privacy and confidentiality of health information. However, **Investors Heritage Life Insurance Company** will protect the privacy of health information in accordance with other applicable state and federal privacy laws and their own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, **Investors Heritage Life Insurance Company** may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that I am entitled to a copy of this signed authorization.

Signature of Personal Representative Date

Description of Personal Representative's Authority or Relationship to Patient
(For death claims, please attach copy of appointment of executor of estate.)

INSTRUCTIONS FOR COMPLETING PROOFS OF DEATH

It is not necessary to employ any person, firm or corporation for collection of any claim under this policy. In addition to completing the CLAIMANT'S STATEMENT on the front of this form, please furnish:

- Official Death Certificate, certificate with raised seal.
- The Policy. If the policy(ies) is (are) lost or destroyed, you must so certify on a separate sheet of paper.
- Evidence of change of name of insured or beneficiary (if applicable).

If death was violent or accidental, consideration of such claim can be facilitated by furnishing a police report, newspaper account, autopsy report and coroner's verdict, in addition to the foregoing.

Form **W-9**
(Rev. January 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification (required): ☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.