

INVESTORS HERITAGE *Life Insurance Company*

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TENNESSEE FUNERAL HOME CLAIMANT STATEMENT

SECTION A - COMPLETE FOR ALL CLAIMS					
1. DECEASED'S LAST NAME			FIRST NAME	MIDDLE NAME	
2. DATE OF BIRTH			3. SOURCE FROM WHICH DATE OF BIRTH OBTAINED <i>(Example: Birth Certificate, Drivers License or Family Bible)</i>		
4. DATE OF DEATH			5. CAUSE OF DEATH		
			6. SOCIAL SECURITY No:		
			7B. POLICY PROCEEDS ASSIGNED TO: (COPY OF ASSIGNMENT REQUIRED)		

8A. FUNERAL HOME NAME		8B. CLAIMANT'S NAME			
ADDRESS		DATE OF BIRTH	AGE	RELATIONSHIP TO DECEASED	
		CLAIMANT'S ADDRESS			
TAX I.D. NUMBER					
EMAIL ADDRESS					
PHONE NUMBER		CLAIMANT'S PHONE NUMBER			

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	

SECTION C — CERTIFICATION OF CLAIMANT

I hereby certify that I am an authorized, licensed Funeral Director; that the above named Insured is deceased as set forth above; that I have prepared for final disposition of the body of the above named person; and that I have fully performed the funeral services for the above named person in accordance with the attached statement of funeral merchandise and services. I hereby certify that all information above is true and correct to the best of my knowledge and belief. A certified copy of the death certificate and the policy should also accompany this form. Investors Heritage reserves the right to request additional information which it, in its sole discretion, deems necessary to adjudicate a claim. ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

SIGNATURE OF FUNERAL DIRECTOR _____ DATE _____ FUNERAL DIRECTOR LICENSE No. _____ SIGNATURE OF WITNESS _____

SIGNATURE OF CONTRACT BENEFICIARY REPRESENTATIVE _____ DATE _____ SOCIAL SECURITY No. _____ SIGNATURE OF 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.

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 administer claims and determine or fulfill responsibility for coverage and provision of benefits.

This authorization shall remain in force for the duration of the claim 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 my representative or 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.)
