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

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'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 knowingly and with the intent to defraud any insurance company or other person files an application for insurance or settlement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.**

Claimant's Signature Social Security # Date Witness

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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: (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.