National Security Insurance Company

P. O. BOX 703 ● 661 EAST DAVIS STREET ● ELBA, ALABAMA 36323
(334) 897-2273 ● 1-800-798-2317 ● FAX 1-800-693-7507

DEATH CLAIM FORM

INSTRUCTIONS

1. The beneficiary should complete all questions and sign at the place indicating Claimant's Signature.
2. If accidental death benefits are involved, please enclose a copy of the investigation report made by the authorities.
3. Enclose a copy of the death certificate. For face amounts of $5,000 or more, a certified death certificate is required.

PROOF OF DEATH—CLAIMANT'S STATEMENT

Full Name of deceased		Date of Death	Date of Birth
Address of Deceased:	**City**	**State**	**Zip Code**
Your Name		**Your Date of Birth**	**Relationship to Insured**
Your Address	**City**	**State**	**Zip Code**

Insured's marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower **Number of surviving children:**

Have you given the funeral home an assignment to collect under this claim? ☐ Yes ☐ No **If "Yes" what amount? $**

If you are not the named beneficiary, who signed the funeral contract (attach a copy)?

Policies deceased held with this company:		Policies deceased held with other companies:	
POLICY NUMBER	**AMOUNT OF POLICY**	**NAME OF COMPANY**	**AMOUNT OF POLICY**

FOR POLICIES LESS THAN 2 YEARS OLD AT THE TIME OF DEATH

List the names and addresses of all physicians who treated the deceased and all hospitals or institutions where he/she was treated within five years of death. (If additional space is needed, please use the back of this form or a separate sheet of paper.)

NAME	ADDRESS

I hereby certify that the above statements are correct:

✓_____ _____ _____

Claimant's Signature **Claimant's Phone Number** **Claimant's Social Security Number**

ANY PERSON WHO KNOWLINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

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