P.O. Box 14410
Des Moines, IA 50306-3410
Phone: 1-800-733-5454
Website: www.gwic.com

Death Benefit Claim Form

Claim Filing Instructions:

- Complete this Death Benefit Claim Form
- Include a Certified Death Certificate indicating cause of death
- Contestable Policies: All Assurance Plus policies within the two year contestable period require a completed Medical Information Authorization (Page 2 of this Claim Form)

Mail Death Claim, Certified Death Certificate, and Medical Authorization (if applicable) to:

Great Western Insurance Company
Claims Dept.
P.O. Box 14410
Des Moines, IA 50306-3410

Claim Process Information:

- Death Claim will begin processing once all required documents have been received by our Claims Department.
- More information may be requested by our Claims Department.
- Any questions should be directed to 1-800-733-5454.

Please PRINT & COMPLETE All Sections:

Name of Insured: ______________________________

Date of Death: ____________________ Birth Date: ____________________

Social Security Number: ____________________ Policy Number: ____________________

<u>Fraud Warning:</u> Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit may be guilty of a crime and may be subject to fines and confinement in prison.

I certify that I am the Beneficiary of the policy listed above. I agree that payment of the policy proceeds in accordance with the policy shall discharge all liability of Great Western Insurance Company under the policy.

______________________________ ____________________
Full Name of Beneficiary (please print) Relationship

____
Complete Address of Beneficiary

______________________________ ____________________
Signature of Beneficiary Date

Medical Information Authorization

Great Western Insurance Company

Please PRINT and complete if Claim is during the first two policy years of an Assurance Plus policy.

I hereby request and authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., or Consumer Reporting Agency having information with respect to any illness, medical history, consultation, prescriptions, or treatments, including x-ray images/plates and copies of all hospital or medical records pertaining the person listed below to release and provide any and all such information to Great Western Insurance Company (The Company) or its legal representative:

____
Printed Name of Insured

The information requested and authorized is to be used in establishing the extent of The Company's liability in a death claim which has been filed for the above person. This authorization may be revoked by written notice to The Company at its Executive Offices in Utah at any time after this authorization has been signed. Any information obtained will not be released by The Company to any persons or organizations except to reinsuring companies, the Medical Information Bureau, Inc., or other person or organizations performing business or legal services in connection with said claim, or as may be otherwise lawfully required or as I may further authorize.

I agree that, unless specifically revoked by written notice to The Company, this authorization will be valid for 120 days after it has been signed.

I know that I may request a copy of this Authorization. I agree that a copy of this Authorization shall be considered as effective and valid as the original.

______________________________	________________
Signature of Next of Kin, Family Representative, or Legal Representative	Date
______________________________	________________
Address/City/State/Zip	Phone

Physician's Information

Please list the physician(s) who treated the deceased during the two years prior to issuance of the Great Western Insurance Policy.

Name: ____________________	Name: ____________________
Address: ____________________	Address: ____________________
____________________	____________________
Phone #: ____________________	Phone #: ____________________

Return to: **Insurance Processing Center** P.O. Box 1, Des Moines, Iowa 50306-0001	*(Home Office Use Only)* Acct:	Dept:

Substitute Form W-9 Request for Taxpayer Identification Number & Certification (2014)

We are required by law to obtain this information when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to 28% Federal income tax backup withholding and you may be subject to a $50 penalty imposed by the Internal Revenue Service under Section 6723.

Complete and return this form. Do not use or photocopy an IRS W-9.

Please Print

Name (as shown on your income tax return)	
Business name/disregarded entity name, if different from above	
Check appropriate box for federal tax classification: ❒ 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) ____	Exemptions (see instructions): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _________________
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, State, and ZIP code	
Policy number(s)	

Part 1: Taxpayer Identification Number (TIN):

Enter your TIN on the appropriate line. 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). For a resident alien who is not eligible to get a SSN, your TIN is your IRS individual taxpayer identification number (ITIN). If you are a sole proprietor and you have an employer identification number (EIN), you may enter either your SSN or your EIN, but the IRS prefers that you use your SSN. If you are a single member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). For other entities, it is your employer identification number (EIN).

Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Employer Identification Number: ___ ___ – ___ ___ ___ ___ ___ ___ ___

Part 2: 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 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 in the instructions.
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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. **The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.**

Signature of U.S. Person: ____ ***Date:*** ______________________________

Please complete the following areas so we may contact you if we have questions regarding the information you provided.

Person completing this form (Print): ____ Phone: (_______) __________________

E-mail Address: ____ Fax #: (_______) __________________

For more information or instructions, please refer to www.IRS.gov or contact our office at the number on the accompanying letter.