SOUTHERN FINANCIAL LIFE
INSURANCE COMPANY

P.O. Box 14410
Des Moines, IA 50306-3410
Fax: 801-675-4685
Phone: 800-995-9010
Email: claims@gwic.com
www.gwic.com

Death Claim Form

Claim Filing Procedures

- Complete the front of this form and fax it to Southern Financial Life Insurance at 801-675-4685.
- Send a copy of the completed death certificate (need not be certified) to the Home Office within 30 days.
- Claims on **First-Day coverage policies, within the two-year contestable period,** need to have a completed death certificate indicating the cause of death attached to this claim form and the Medical Information Authorization, on reverse, completed before payment will be made. Refund of premiums paid will be made immediately upon receipt of this form; all other amounts will be paid after the medical information and death certificate are received and reviewed.
- Claims on policies where the funeral home is not an assignee or beneficiary must be accompanied by a valid assignment with family signature and a filed death certificate.
- Any questions should be directed to the Claims Department at the Home Office, 800-995-9010.
- Remit an itemized statement (highly recommended).

Proof of Death—to be completed by the Funeral Director/Beneficiary/Assignee

Name of Insured: _____ Policy #: _____

Social Security Number: _____ Birth Date:_____ Death Date: _____

Primary Cause of Death: ☐ Natural ☐ Accidental ☐ Suicide

Is the Away-from-Home Benefit being applied for? ☐ Yes ☐ No
(This benefit is for death occurring 250 or more miles from primary residence, on a policy of $2,000 or greater.)

Family Representative arranging services: _____

Amount to be paid to Funeral Home: ☐ Entire Benefit ***or*** ☐ Specific Amount $_____ and

the balance to _____ (please provide address below).

I certify as a legal representative of the listed funeral home that: 1) we are providing the funeral services and merchandise for the deceased insured, 2) we have legal claim on the proceeds of the policy by assignment or as beneficiary and authorize their release, 3) we agree that this payment will discharge in full all liability of the company under the Policy(ies), and 4) we will indemnify Southern Financial Life Insurance Company if the policy proceeds are paid to us incorrectly.

Funeral Home: _____ License #:_____

Address:_____
Street Number/PO Box Number, City, State, ZIP

_____ Phone #:_____ Date: _____
Signature of Licensed Funeral Director/Funeral Home Representative

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

I certify that I am the Beneficiary of the policy(ies) listed above and entitled to grant release of the proceeds. I agree that such payment shall discharge all liability of the company under the policy(ies).

_____ Date: _____
Signature of Beneficiary/Legal Family Representative

_____
Street Number/PO Box Number, City, State, ZIP

Medical Information Authorization

(Required if a First-Day coverage policy has been in effect less than 2 years)

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., Consumer Reporting Agency, or employer having information with respect to any illness, medical history, consultations, prescriptions, or treatments, including x-ray plates and copies of all hospital or medical records pertaining to _____ to release and provide any and all such information to Southern Financial Life Insurance Company (the "Company") or its legal representative.

The information requested and authorized is to be used in establishing the extent of the Company's liability in a 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 persons 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 or Family Representative | Date

_____ _____

Address | Phone Number

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

_____ _____

Physician's Name | Physician's Name

_____ _____

Address | Address

_____ _____

Phone Number | Phone Number