GWIC® GREAT WESTERN 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

Texas Claim Form

When filing a claim, please complete this form and attach the following documents:

A. An itemized statement of funeral expenses (At-need goods & services contract).
B. A certified copy of a Death Certificate.
C. If the policy has been in force less than two years, complete the Authorization to Release Medical Information on the reverse side of this form. The claim amount may be reduced until verification is received of the insured's health status at the time the policy was issued.
D. If you are not the original funeral home provider, include a completed pre-need assignment to at-need provider form.

SEND OR FAX the above items to: Great Western Insurance Company
P.O. Box 14410
Des Moines, IA 50306-3410 Fax Number: 801-675-4685

Please direct any comments or questions to the Claims Department at 800-995-9010.

CLAIMANT'S (Family Representative) & MORTUARY'S STATEMENT and AUTHORIZATION OF PAYMENT

We the undersigned hereby submit proof of death of _____ and state that the Insured was born on _____ and died on _____ and at the time of death was insured under policy number(s) _____.

1. What relation is claimant to deceased? _____
2. Is the claimant the beneficiary? ☐ Yes ☐ No If "No," the beneficiary is _____
3. What is the (non-funeral home) beneficiary's Social Security number? _____
4. Is this claim associate with a pre-need Funeral Services Agreement? ☐ Yes ☐ No If "Yes," list the funeral services and merchandise amount itemized in the agreement, $_____ and the cash advance amount, $_____.
5. Name and address of mortuary providing service: _____

   _____
6. The policy(ies) ☐ is lost ☐ was received and destroyed by the mortuary ☐ was returned with this claim
7. GREAT WESTERN INSURANCE COMPANY IS HEREBY AUTHORIZED TO PAY THE ABOVE NAMED MORTUARY (Check one) ☐ THE FULL DEATH BENEFIT, ***OR*** ☐ THE SUM OF $ _____ subject to the provisions of the above listed policy(ies) and the balance to _____ as payment on a funeral for the Insured.

We hereby agree that the designated mortuary has performed the services requested for the funeral of the Insured and my receive and receipt the above designated amount due and payable under the aforementioned policy(ies), which receipt shall be conclusive acknowledgment that we have received from the Company the sum specified in settlement of the policy(ies) listed above.

If the claimant is not the listed beneficiary on the policy, the claimant hereby acknowledges that he/she has authority to complete this authorization.

_____ Signature of mortuary representative

_____ Signature of next of kin/family representative

_____ Mortuary providing services

_____ Address

_____ Date

_____ City, State, ZIP

Authorization to Release Medical Information

(Complete only if the policy is a non-guaranteed issue and has been in force 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 or injury, 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 Great Western Insurance Company or its legal representative.

The information requested and authorized is to be used in establishing the extent of Great Western'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 Great Western Insurance 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 photostatic 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 purchasing the Great Western Insurance policy.

_____ _____

Physician's name | Physician's name

_____ _____

Address | Address

_____ _____

_____ _____

Phone number | Phone number

**** * * For your protection, State law requires the following warning to appear on this form. * * ****

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.