KEMPER Life

DEATH CLAIM - CLAIMANT'S STATEMENT

SUBMIT ALL CLAIM RELATED DOCUMENTS TO:
KEMPER LIFE INSURANCE SERVICES
12115 LACKLAND RD
ST. LOUIS, MO 63146
FAX: 314-819-4391 EMAIL: lifm28@kemper.com
* Fax or email preferred

Please use this form to submit a claim under a policy with one or more of the following Kemper Life companies: United Insurance Company of America, The Reliable Life Insurance Company, h v] } v E Ÿ } v o >] (/ v • µ Œ v } u ‰ v Ç U } Œ Insurance Company.

PLEASE TYPE OR PRINT THE FOLLOWING INFORMATION

1. DECEDENT/INSURED AND POLICY INFORMATION

Name of Insured (Deceased)_____ Social Security No. _____

>] • š o } Á v Ç } š Z Œ v u • Ç Á Z] Z š Z / v • µ Œ Á • l v } Á v ~] v o µ u] v v u U v]

(_____) (_____)(_____

Date of Birth: _____ Date of Death: _____

Cause of Death Œ E ‹ µ] Œ ‰ Œ] } Œ š } ‰ Œ } • •] v P): ‰ Heart & Circulatory System ‰ Respiratory System ‰ Cancer

‰ Mental or Nervous System ‰ Other (please specify): _____

Street Address of Insured: _____

City: _____ State: _____ Zip Code: _____

List any other states where the insured may have lived: _____

PROVIDE THE NUMBERS OF ALL POLICIES ON WHICH CLAIM IS BEING FILED:

2. BENEFICIARY/CLAIMANT INFORMATION

E u } (v .] Œ Ç l o] u v š W z z z z z z z z z z z z z z z z z z z z z z z z z z z z z Z o Ÿ } v • Z] ‰

Social Security #: _____ Phone #: (_____)_____ Date of Birth: _____

Mailing Address: _____

City: _____ State: ____ Zip Code: _____ Email address: _____

E u } (v .] Œ Ç l o] u v š W z z z z z z z z z z z z z z z z z z z z z z z z z z z z z Z o Ÿ } v • Z] ‰

Social Security #: _____ Phone #: (_____)_____ Date of Birth: _____

Mailing Address: _____

City: _____ State: ____ Zip Code: _____ Email address: _____

3. ASSIGNMENT OF INSURANCE PROCEEDS

, À Ç } µ } Œ v Ç } v o • • •] P v } Œ] v š v š } • •] P v v Ç ‰ } Œ Ÿ } v } (š Z ‰ Œ }
funeral home or any other party for the purpose of covering funeral expenses or for any other reason?
‰ Yes ‰ E } / (Ç • U ‰ Œ } À] š Z v u v Œ • • } (• µ Z . Œ u } Œ ‰ Œ

_____

4. MANNER OF DEATH

‰ E š µ Œ o µ • • ~ • µ Z • Z Œ š © l U v Œ U ‰ Homicide
‰ Accidental (such as motor vehicle accident, drug overdose, etc.) ‰ Suicide

DEATH CLAIM - CLAIMANT'S STATEMENT (PART TWO)

5. DOCTOR/HOSPITAL INFORMATION

IF ANY POLICY IS LESS THAN TWO YEARS OLD OR IF THE DEATH WAS BY ACCIDENTAL MEANS, PLEASE COMPLETE TH
W o • o] • š v Ç } š } Œ • U Z } • ‰] š o • U } Œ u] o ‰ Œ } À] Œ • š Z š š Œ š š Z] v • µ Œ

FRAUD WARNING NOTICES

material thereto commits a fraudulent insurance act, which is a crime.

VIRGINIA: WARNING: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED THE STATE LAW.