United American Insurance Company
PO Box 8076
McKinney, TX 75070
f: 405-270-1496 | Claims@Globe.Life

Underwritten by United American Insurance Company

Please carefully read all of the following information before completing this statement.

Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Arkansas, Louisiana, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following notice regarding false statements and information: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly or with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Indiana: Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with 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 is guilty of insurance fraud.

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

Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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Claimant Statement

Instructions

1. Claimant's Statement (Page 3) should be completed for all claims and must be executed by the beneficiary or beneficiaries named in the policy. The 'Beneficiary's Information' (including insured's Social Security Number/Taxpayer ID) is required for each claimant.
2. If the beneficiary is a minor, or is otherwise incapacitated, the Claimant's Statement (Page 3) must be executed by the guardian with letters of guardianship attached.
3. If any named beneficiary in the policy died before the insured, a death certificate of such deceased beneficiary must be attached.
4. Where the claimant is the executor or administrator of the estate of the insured, such person should complete the Claimant's Statement (Page 3), and letters testamentary or letters of administration must be attached.
5. Complete pages 5 and 6 (Statement of Physician) if death occurred within the first two years of the policy issue date.

Insured's Information

1. Insured/Deceased's Name in Full

List any other names by which the deceased may have been known such as maiden name, hyphenated name, nickname, alias, or derivative form of first and/or middle name

2. Insured Social Security Number/Taxpayer ID

3. Union/Local or Worksite, if applicable

4. Policy Number(s)

5. Insured/Deceased's Birth Date

6. Date of Death

7. Cause of Death

8. Residence of Insured/Deceased at Death (Street Address, City, State, ZIP)

9. **Is any policy less than two years old?** ❑ **Yes** ❑ **No** If "Yes," also complete pages 5 and 6. If "No," complete pages 3 and 4 only.

10. **Was the death ruled an accident or a homicide?** ❑ **Yes** ❑ **No** If "Yes," please also include the autopsy, toxicology, and police reports, a certified copy of the coroner's report and copies of dated newspaper articles.

Beneficiary's Information – About You

Signature 1 _____ Print Name _____

Address (Street Address, City, State, ZIP) _____

Social Security Number/Taxpayer ID _____ Date of Birth _____ Age _____

Phone: Home _____ Work _____ Email Address _____

Relationship to Deceased _____ Date _____

Signature 2 _____ Print Name _____

Address (Street Address, City, State, ZIP) _____

Social Security Number/Taxpayer ID _____ Date of Birth _____ Age _____

Phone: Home _____ Work _____ Email Address _____

Relationship to Deceased _____ Date _____

United American Insurance Company and I agree that this Claimant's Statement may be electronically signed. By typing my name above, I hereby agree that my electronic signature shall have the same effect as if it were handwritten. Further, I hereby attest that the information given herein is true and accurate to the best of my knowledge, and I understand that any false, misleading or fraudulent information may subject me to civil or criminal liability.

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Certification

You certify the following by signing this document:

- The information you have provided — in its entirety — is true, complete, and accurate to the best of your knowledge.
- In the event we overpay you, we reserve the right to reclaim the total amount we overpaid. Examples of when we can reclaim the overpayment include, but are not limited to,: (i) if we discover we've paid you more than your life insurance claim entitles you to, or (ii) if payment was meant for someone else but was instead paid to you. You agree to repay us the amount we overpaid. If you do not repay us, you understand that we may take steps including but not limited to legal action to recover the overpayment in full.
- You have thoroughly read and understand the Claim Fraud Warnings included with this form.

Signature of person making the claim

Date signed (mm/dd/yyyy)

US Only

Failure to complete this section may subject you to backup withholding.

Under the penalties of perjury, I certify:

1. That the number shown as my Social Security Number/Taxpayer ID in "Section 1: About you" above is my correct taxpayer identification number, and

2. That 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 a 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, resident alien, or other U.S. person*, and

4. I am not subject to FATCA reporting because I am a U.S. person* and the account is located within the United States.

(Please note: If the Internal Revenue Service has notified you that you are currently subject to backup withholding because you failed to report all interest or dividend income on your tax return, you are required to cross out Item 2 above.)

*If you are not a U.S. Citizen, a U.S. resident alien, or other U.S. person for tax purposes, complete and submit form W-8BEN (for individuals) or W-8BEN-E (for entities).

The Internal Revenue Service does not require that you consent to any provision of this document except for the certifications required to avoid backup withholding.

Signature of person making the claim

Date signed (mm/dd/yyyy)

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Policy Number(s) _____ _____ _____

Statement of Physician

This statement should be completed by the Insured's Primary Care Physician.

Full name of patient?	Name	Age
How long have you treated the patient?		
Were you the patient's medical attendant or adviser before last illness or infirmity? If so, when and for what disease?		
When was the patient diagnosed with the disease or impairment that resulted in death?		
Was the patient ever treated for drug or alcohol abuse? If so, please list dates and locations of treatment.		
Was the patient ever disabled? If so, when and for what reason?		
From what other disease or impairment has the patient suffered, and when?	Disease or Impairment	Duration
Was the patient confined to a hospital during the past 3 years? If so, provide name and address of the hospital.		

Give names and addresses of physicians or other practitioners who, to your knowledge, attended to the deceased during the past five years.

Name	Address	Disease or Impairment

Physician's Name (PRINT) _____ Physician's Signature _____

Street Address _____ City, State, ZIP _____

Fax Number _____ Phone Number _____

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Authorization for Release of Insured's Health Information Pursuant to HIPAA

Insured's Name:	Insured's Date of Birth:	Insured's Social Security Number/Taxpayer ID:
Policy Number:	Policy Number:	Policy Number:
Insured's Address:		

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, MIB, Inc., or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the United American Insurance Company (UA) and its agents, employees, and representatives. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that UA may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and/or 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with UA.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to UA to the attention of the Underwriting Department at the above address. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization, and that, to the extent that UA has a legal right to contest a claim under an insurance policy or to contest the policy itself, such revocation may prevent UA from completing their review of policy claims. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, UA may not be able to process my application, or if coverage has been issued, may not be able to process policy claims. I acknowledge that I have received a copy of this authorization.

Name and address of person(s) or category of person to whom this information will be sent:

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If not the patient, name of person signing form:

Authority to sign on behalf of patient:

☐ Parent ☐ Legal Guardian ☐ Next of Kin ☐ Child ☐ Spouse ☐ Executor of Estate

☐ Other (please specify relationship to insured) _____

IMPORTANT: If the patient is deceased, please **INITIAL** one of the statements below:

☐ I am the Administrator/Executor for the deceased and Letters of Testamentary, Executor of Estate documents, or other comparable documentation is enclosed.

☐ There is no court appointed Administrator/Executor and I am the Next of Kin.

All items on this form have been completed and my questions about this form have been answered, and I have been provided a copy of this form.

Signature of patient or personal representative **Date Signed**