Proofs of Death Submitted to:

NATIONAL INCOME LIFE INSURANCE COMPANY
C/O NILICO Service Center

PO BOX 2500 • Waco, TX 76702
Phone (800) 516-4466 • Fax (254) 741-5705
Web www.nilife.com • Email CL@nilife.com

INSTRUCTIONS FOR SUBMITTING A LIFE CLAIM

1) Complete as Follows:
   - **Part A** and **C** by the Beneficiary, Guardian or Personal Representative for all claims.
   - **Part B** by the Beneficiary - **To be completed only if policy is less than 2 years old.**
   - **Part D** by the Physician - **To be completed only if policy is less than 2 years old.**
   - **Part E** by the Beneficiary - Complete Authorization for Release, sign and date.
2) To expedite Payment, all questions must be answered fully and accurately.
3) Send this completed form, along with a Death Certificate **(Certified Death Certificate required if face amount exceeds $15,000),** and Obituary (if available) to one of the above.

Part A - To be Completed by Beneficiary

Policy Numbers			
Deceased's Name	Deceased's Date of Birth	Deceased's Gender ☐ Male ☐ Female	Deceased Union and Local # *(if Union member)*
Deceased's Address	Did Death Result From: ☐ Suicide ☐ Homicide ☐ Accident If yes, please include all Accident/Police Reports and Newspaper Articles		
Date of Death	Place of Death (if Hospital, Give Name)	Cause of Death	
Beneficiary's Name	Beneficiary's Relationship to Insured		
Beneficiary's Mailing Address	Beneficiary's Telephone Number / Beneficiary's Social Security Number		
Beneficiary's Email Address	Beneficiary's Date of Birth		

Part B - To be Completed by Beneficiary **COMPLETE ONLY IF POLICY IS LESS THAN 2 YEARS OLD**

Give the names and addresses of all physicians who treated the deceased during the 5 years prior to death:

Name	Address	Disease or Condition	Dates

When did deceased first complain, or give other indication of illness?	When did deceased first consult a physician for last illness?

Part C - AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Insured's Name	Date Of Birth	Social Security 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, Medical Information Bureau (MIB), 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 National Income Life Insurance Company (NILICO) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco; but excludes psychotherapy notes.

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 NILICO may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with NILICO.

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 NILICO, Attention: Claims 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 or to the extent that NILICO has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed 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, NILICO may not be able to process my claim or make any benefit payments. 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	Name of person signing form:
National Income Life C/O NILICO Service Center PO Box 2500, Waco, TX 76702	
Authority to sign on behalf of deceased. ___ Parent ___ Legal Guardian ___ Child ___ Spouse ___ Next of Kin ___ Executor of Estate ___ Other (please specify relationship to Insured) - _____	

All items on this form have been completed and my questions about this form have been answered. National Income Life Insurance Company and I agree that this Claimant's Statement may be electronically signed. By typing my name below, 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.

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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____ _____

Signature of Patient/Beneficiary/Guardian or Personal Representative Date

Please make a copy of this authorization and retain for your record.

Part D - To be Completed by Physician	COMPLETE ONLY IF POLICY IS LESS THAN 2 YEARS OLD	
Deceased's name	Manner of Death	Date of Death
How long have you treated this 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 the name and address of the hospital.		

Give names & addresses of the referring physicians or other practitioners who, to your knowledge, attended the patient during the past 5 years

Name	Address	Disease or Impairment	Dates

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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Physician's Name (PRINT)

Street Address

Physician's Signature

City State Zip

Fax Number

Phone Number

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date Of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a). I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
   A.I. Records, P.O. Box 2608, Waco TX 76702

9(a). Specify information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____
  _____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
INSURANCE	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

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

_____ Date: _____
Signature of Patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**