F. AFFIDAVIT

1. Has or will an Estate be probated in a court of law?

_____

_____

X _____

Signature of Claimant

If an Estate **is** probated, the Executor or Administrator of the Estate must submit the legal letters of administration.

2. Applicable only if NO ESTATE is probated:

I agree that if I receive the proceeds of the policy/certificate, I will apply the proceeds to final expenses incurred by the deceased. Final expenses may include the funeral bill, hospital, or doctor bills. I further agree that I will divide equally with the deceased's heirs at law, any amount in excess of the amount used for final expenses.

X _____

Signature of Claimant

_____

Relationship to Deceased

_____

Date

W51-TX Rev. 1110

HOMESTEADERS LIFE COMPANY

FILING A CLAIM

Texas

A certified Death Certificate is required.

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

INSTRUCTIONS:

1. Have Beneficiary complete Claimant's Statement, Part "A," and sign it. List SS# or Tax I.D. #.
2. Obtain the Policy/Certificate or have Beneficiary complete Lost Policy/Certificate Statement, Part "E."
3. Obtain copy of Death Certificate ***or*** Physician's Statement, Part "B," ***or*** Proof of Death, Part "C," if permitted.
4. Complete Authorization, Part "D," when applicable.
5. Have claimant complete Affidavit, Part "F," if applicable.
6. Send all to our Claims Department, P.O. Box 1756, Des Moines, IA 50306.

By furnishing forms and investigating the claim, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

A. CLAIMANT'S STATEMENT

Policy(ies)/Certificate(s) of this Company under which claim is being made:

Policy/Certificate Number _____ Policy/Certificate Number _____

Policy/Certificate Number _____ Policy/Certificate Number _____

1. (a) Deceased's Name in full _____
   (b) Residence Address _____
2. Date of BIRTH of deceased _____ Obtained from: _____
3. Date of DEATH _____ Place of Death _____

NOTE: This area ***MUST*** be completed **if the policy/certificate is less than two (2) years old.**

4. Names and addresses of all physicians or practitioners who attended or prescribed for deceased within the five years preceding death:

Names	Addresses	Dates of Attendance	Disease or Condition

5. Facts concerning other life and health and accident insurance on the life of deceased:

Name of Company	Date of Policy	Amount of Insurance

The undersigned agrees that these proofs of death shall include all medical information and papers supplied by any physician, medical practitioner, hospital, or medical facility, who treated the deceased.

RELEASE OF INFORMATION

The undersigned authorizes any physician, medical practitioner, hospital, or medical facility to release to Homesteaders Life Company, if requested, all medical information and papers concerning the deceased.

The release shall be valid for one year from this date. A copy of this release is as valid as the original.

Under penalties of perjury, I certify that the information provided on this form is true, correct, and complete.

☐ ***Check here if you are subject to backup withholding (Section 3406[a][c]IRC)***

Dated this _____ day of _____, _____

X _____ X _____ _____

Signature of Beneficiary/Claimant **Social Security # or Tax I.D. #** Telephone #

_____ _____ _____ _____ _____ _____

Relationship Age Address City State Zip

X _____ X _____ _____

Signature of Beneficiary/Claimant **Social Security # or Tax I.D. #** Telephone #

_____ _____ _____ _____ _____ _____

Relationship Age Address City State Zip

This Claimant's Statement must be signed by the person legally entitled to the proceeds of the Policy/Certificate. Failure to provide SS# or Tax I.D. # could result in withholding of 28% on interest earned.

B. / C. PHYSICIAN'S STATEMENT

PROOF OF DEATH

NOTE: A Certified Death Certificate must be mailed or faxed (800-867-9849) to Homesteaders Life Company.

AUTHORIZATION FOR PAYMENT OF PROCEEDS TO FUNERAL HOME

HOMESTEADERS LIFE COMPANY • DES MOINES, IOWA

SUBJECT TO PROVISIONS OF POLICY(IES)/CERTIFICATE(S) NO(S) _____

(Only the proceeds of those policy(ies)/certificate(s) listed will be authorized for payment.) _____

I HEREBY AUTHORIZE AND DIRECT YOU TO PAY TO:

_____ Entire proceeds OR $ _____

Name and Address of Funeral Home

IF MORE THAN ONE BENEFICIARY, PLEASE HAVE ALL SIGN.

DATE _____ X _____

Signature of Beneficiary/Claimant

DATE _____ X _____

Signature of Beneficiary/Claimant

FUNERAL DIRECTORS–ASK ABOUT OUR PHONE-A-CLAIM® SERVICE AVAILABLE TO FUNERAL HOMES!

LOST POLICY/CERTIFICATE STATEMENT

I, _____, do hereby certify that I have made a diligent search for policy(ies)/certificate(s) _____ _____ issued by Homesteaders Life Company to _____ and that I am beneficiary as shown by the records of the Company on said policy(ies)/certificate(s).

I further state that it is my belief that said policy(ies)/certificate(s) has/have been lost or destroyed; however, if any person has possession of such policy(ies)/certificate(s) and makes a claim against Homesteaders Life Company based on claim on an interest therein, I agree to indemnify and hold Homesteaders Life Company harmless from all such claims and expenses in connection therewith in consideration of Homesteaders Life Company paying me the proceeds of said policy(ies)/certificate(s) based on this instrument.

Dated and signed at _____ this _____ day of _____, _____.

Witness _____ Beneficiary _____