Reset

NOTICE OF CLAIM FOR DEATH BENEFITS

NAME OF CREDITOR

ADDRESS

CITY STATE ZIP

AGENT CODE LOAN EFF. DATE

POLICY/CERTIFICATE #

LOAN ACCT. #

INSTRUCTIONS TO CLAIMANT

1. Complete this form as soon as possible after death of insured.
2. Have nearest next of kin complete reverse side and return to you.
3. When this form is fully completed, attach:
   (a) Certified copy of Death Certificate
   (b) Cancellation Copy of Policy/Certificate
   (c) Copy of Loan Contract
   (d) If MOB, Copy of Ledger Sheet, Note, Amortization Schedule

Beyond the expected® PEKIN® INSURANCE

PEKIN LIFE INSURANCE COMPANY
2505 COURT STREET, PEKIN, ILLINOIS 61558
Phone: 309-346-1161 Ext. 3123 Fax: 309-478-2093

CLAIM DIVISION

PROOFS OF DEATH – CLAIMANTS STATEMENT

To be completed by Creditor

Full Name of Deceased _____ Age on Policy/Certificate _____

Address _____ Date of Death _____

City _____ State _____ Zip _____ Last 4 digits of deceased's Social Security # _____

Policy/ Certificate #	Loan #	Date of Policy/Certificate	Original Term	Initial Amount of Insurance	Minus Reduction Amount	= Claim Amount
				$	$	$
				$	$	$

TOTAL CLAIM $ _____

Amount Due Creditor Beneficiary _____ $ _____

Indiana Claims: A 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.

Ohio Claims: 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 false or deceptive statement is guilty of insurance fraud.

Arkansas and Louisiana Claims: 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.

I hereby certify that the answers given above are full and true:

_____ NAME OF ISSUING AGENCY

_____ NAME OF CREDITOR BENEFICIARY ON POLICY/CERTIFICATE

_____ ADDRESS OF ISSUING AGENCY OFFICE

_____ ADDRESS CITY & STATE

Dated, this _____ , 20 _____ Signature_____

Title _____ Print Name _____

Subscribed and sworn to before me this _____ day of _____ , 20_____

_____ SIGNATURE AND SEAL OF NOTARY OR JUSTICE

LK 14 (Rev. 03-17)

PEKIN LIFE INSURANCE COMPANY
2505 Court Street
Pekin, IL 61558

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TO BE COMPLETED BY THE NEAREST NEXT OF KIN:

1. Deceased's Name: _____ Last 4 Digits of Social Security # _____

   Please list any other names by which insured may have been known. _____

   _____

   (Include maiden name, hyphenated name, nickname, derivative form of first and/or middle name, or alias.)

   Date of Birth _____ Occupation at Death _____ Date Last Worked _____

2. When did deceased first complain or give other indications of this illness? _____

3. When did deceased first consult a physician for this illness? _____

4. Names and addresses of all physicians who treated the deceased within five years preceding death:

   Family Doctor _____ Street, City, State _____

   Dates of Treatment _____ Disease or Condition _____

   Name _____ Street, City, State _____

   Dates of Treatment _____ Disease or Condition _____

   Name _____ Street, City, State _____

   Dates of Treatment _____ Disease or Condition _____

   Name _____ Street, City, State _____

   Dates of Treatment _____ Disease or Condition _____

5. Names and addresses of all hospitals where deceased was confined:

   Name _____ Street, City, State _____

   Dates of Treatment _____ Disease or Condition _____

   Name _____ Street, City, State _____

   Dates of Treatment _____ Disease or Condition _____

   Name _____ Street, City, State _____

   Dates of Treatment _____ Disease or Condition _____

I hereby certify that the answers given above are full and true:

DATE _____ **Relationship to Deceased** _____ _____

(Signature)