

DEATH CLAIM ADMINISTRATION FORM

Kanawha Insurance Company, Benefits Department,
P.O. Box 2000, Lancaster, South Carolina 29721-2000

Part 1

I hereby make claim for the death benefits under Policy Number _____ on the life of _____
(Full Name)
insured by the Kanawha Insurance Company.

Deceased's Date of BIRTH _____ Date of DEATH _____

Place of death _____
(if in hospital, give name and address of hospital)

Cause of death _____

State your relationship to Deceased _____ YOUR date of birth _____

Your Social Security Number _____

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 subject to prosecution and punishment for insurance fraud.

Part 2

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that in furnishing these forms, the Company does not acknowledge liability or waive any of its rights or defenses.

Witness my Hand at _____ this _____ day of _____, 20 _____

Signature of Agent/Notary Public

Signature of Beneficiary

Address

City State Zip

Part 3

Authorization To Release Information:

I hereby authorize any physician, hospital, pharmacy, employer, dentist, coroner/medical examiner, law enforcement agency, insurance organization, consumer reporting agency, or other person or entity possessing any medical information, any information about insurance policies/benefits, or any other information to release all information to Kanawha Insurance Company. This includes any drug, alcohol, psychiatric, HIV infection or AIDS related treatment. A photocopy shall be as valid as the original. The authorization is valid six (6) months from the date signed.

Date Signature Address

If signed on behalf of another, give relationship: _____