National Teachers Associates Life Insurance Company

Attn: Claims Department
P.O. Box 2369 ◆ Addison, TX 75001-2369
(972) 532-2100 ◆ (888) 671-6771
FAX: (972) 532-2192

CLAIMANT'S STATEMENT

INSTRUCTIONS FOR FILING PROOF OF LOSS

1. This form is to be completed by the person or persons to whom the policy is legally payable as beneficiary.
2. If the beneficiary is the insured's estate, the statement should be completed by the executor or administrator and a certified copy of the appointment issued by the proper court and bearing the clerk's signature must be furnished.
3. If the beneficiary is not of legal age, a guardian should complete the form and submit a certified copy of the appointment issued by the proper court and bearing the clerk's signature.
4. **A certified copy of the Official Certificate of Death, certified by the issuing agency, must be supplied to the Company.**
5. Return the original Policy with this form.
6. Please **print or type** all information except signatures.

Warning: 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.

INFORMATION CONCERNING THE INSURED

1. Name (Full Legal) ______________________________

2. Date of Death: (Mo., Day, Year) ______ / _____ / _____ Date of Birth: (Mo., Day, Year) _______ / _____ / ______

3. List all NTA Life insurance policies for which this claim is being made: (Provide all letters and numbers)

______________________ ______________________ ______________________

All policies listed above must be submitted with your claim. If policies are not attached, please explain why:

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4. Names, addresses & phone numbers of all physicians who have treated the insured in the past three (3) years: ______________

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INFORMATION CONCERNING THE CLAIMANT

1. Name (Full Legal) ______________________________

2. Address: (Include street name & number, city, state & zip)

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3. In what capacity are you making this claim? ______________________________

4. Your social security number: _______ - __________ - ________ Your relationship to the deceased: ____________________

5. Your date of birth: ________ / _______ / _________ ❑ Male ❑ Female

6. Your phone number (in case we need to contact you):

Daytime ( ) ______________________ Evening: ( ) ______________________

AUTHORIZATION TO OBTAIN INFORMATION

I authorize you to give National Teachers Associates Life Insurance Company and/or its reinsurers or its agents: (a) all information you have as to illness, injury, medical history, diagnosis, treatment and prognosis with respect to any physical or mental condition of the patient; and (b) any non-medical information about the patient which the Company believes it needs to perform the business functions described. This form will be valid for the duration of the claim. I agree that a copy is as valid as the original.

Signature of Beneficiary / Guardian / Executor ______________________________ Date signed: _______________