# Individual Life Claim Form

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Submitted to Life Claims Department
Mail Processing Center, P.O. Box 10466, Springfield, MO 65808-0466
Phone: (800) 615-7372



**American National Insurance Company**
**American National Life Insurance Company of New York**
**American National Life Insurance Company of Texas**
**Garden State Life Insurance Company**
**Standard Life and Accident Insurance Company**

* L I F E C L M *

**In order to process your claim as quickly as possible we need some information about you and the insured. Please submit the insurance policies, and a certified death certificate along with pages 1, 2, and 3 of the claim form. Each claimant must submit his or her own claim form. Only one certified death certificate is necessary.**

## A. Insured Information

1. Insured's Name _____
2. Date of Birth _____
3. Please list all life insurance policy numbers on which you are filing claim.

   _____ _____

   _____ _____

4. To assist us in searching for any additional insurance coverage please provide us with any other names used by the insured or any other spelling of the name of the insured, including any aliases.

   _____

   _____

## B. Policy Information

1. Is the policy lost? ☐ Yes ☐ No
2. Has the policy been assigned to a Mortuary, Funeral Home, or Cemetery? ☐ Yes ☐ No If yes, please enclose a copy of the assignment.
3. Has the beneficiary's name changed? ☐ Yes ☐ No If yes, please explain _____

## C. Claimant Information

1. Claimant's Name _____ Date of Birth _____
2. Social Security, Trust/Estate/Tax Identification Number _____
3. If you are claiming on behalf of a minor child, please provide the child's name, address, Social Security Number and Date of Birth.

   _____

4. Phone Number (in case we need to contact you) Day _____ Evening _____
5. Address _____
   Number Street Name Apt/Box # (if any) City State ZIP
6. Your relationship to the insured (Explain) _____
7. Email Address (optional) _____

## D. Illinois Notice

For beneficiaries residing in Illinois interest shall accrue on the proceeds payable because of the death of the insured, from the date of death, at a rate of 10% on the total amount payable or the face amount if payments are to be made in installments until the total payment or first installment is paid, unless payment is made within thirty-one (31) days from the date of receipt by the company of due proof of loss.

**(Please complete and return pages 1, 2, and 3. Be sure to sign pages 2 and 3.)**

## Authorization

NOTE: This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and other applicable federal and state privacy laws. You are not required to sign the authorization, but if you do not, your claim form may not be able to be evaluated or processed. Please sign and return this authorization with the claim form to the address on the first page of this claim package.

# AUTHORIZATION

I have filed a claim for life insurance benefits with AMERICAN NATIONAL INSURANCE COMPANY, AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK, AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS, GARDEN STATE LIFE INSURANCE COMPANY, or STANDARD LIFE AND ACCIDENT INSURANCE COMPANY (the "Companies") on the death of _____ (Name of Deceased).

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, pharmacy, pharmacy benefit managers, group policy holder, benefit plan administrator, the MIB, LLC, government agency, and paramedical facility to provide the Companies, and their duly authorized representatives, data or records containing information regarding medical history and treatment including advice, care or treatment sought by the deceased. The data or records may include information relating to medical history, medical conditions, treatment, hospitalizations, including AIDS/HIV, or confinements, ailments and/or drug, alcohol, or tobacco usage and mental illness of the deceased.

I also authorize any employer, law enforcement agency, financial institution or other individual or organization to provide the Companies, and their duly authorized representatives, data or records containing information regarding employment, income, driving records or other information necessary to evaluate and process the claim.

It is understood that the information obtained by this authorization will be used to evaluate this claim and may be transferred to any reinsurer, agency, insurance support organization or person employed by the Companies to assist with this purpose. I understand that when information that is covered by HIPAA is disclosed to an entity that is not subject to HIPAA, the information may be redisclosed by the recipient and may no longer be subject to the protections of HIPAA. However, I understand that disclosed information may be redisclosed only in accordance with other applicable federal and state privacy laws.

This authorization is valid for two years from the date below or the duration of this claim, whichever period is shorter. I understand I have the right to request a copy of this authorization and that a copy of this authorization will be sent to me if requested. A photographic or electronic copy of this form will be as valid as the original.

I may revoke this authorization in writing at any time except to the extent that the Companies have relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand that if I revoke this authorization or if I alter its content in any way, the Companies may not be able to evaluate or administer this claim and this may be the basis for denying this claim.

1) By furnishing proof of death forms the Companies do not waive any available legal defenses;
2) I am not currently subject to IRS required backup withholding as a result of failure to report all interest or dividend income;
3) I certify, under penalty of perjury that the information and Social Security Number(s) on this claim form are true and correct;
4) **I have read the applicable state Claim Fraud Warning provided in this form. NEW YORK RESIDENTS: 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

_____

Claimant's Signature Date

**Name of Beneficiary** _____ **Policy #** _____

## Method of Payment Requested

The insurance policy or contract may have provided settlement options for payment of your proceeds. If a settlement option has been selected for you, more information will be provided as your claim is processed. Unless the policy owner preselected a specific method of settlement prior to the insured's death, you may choose to receive the benefit in a lump sum payment or in periodic payments. Please select your preferred method of payment from the options below.

(a) Lump sum settlement? ☐ Yes ☐ No

(b) If a settlement option is available, state type of settlement desired. (Before selecting a settlement option we suggest that you consider consulting your attorney or accountant to determine if there are any IRS or state tax implications for the option you elect.)

Payment Options:

☐ Fixed Payments - We will pay the benefit amount with accrued interest to you in equal installments over a specific period of time.

☐ Life Income - We will pay the benefit amount with accrued interest to you for the remainder of your life.

☐ Interest** choose one below

☐**Accrued interest paid annually OR ☐** Interest to Accumulate

Interest will be paid at a rate determined in the insured's policy.

If you selected Fixed Payments, the payments will be made for *5 years unless otherwise requested*. You may choose to receive payments for a period *other* than 5 years. Please state the number of years payments are to be received. _____

Frequency of Payments:

☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

List the person who will receive the proceeds in the event you die before receiving the full benefit.

Name _____ Date of Birth _____ Relationship _____

SSN _____ Address _____

I understand that I am entitled to receive the death claim benefits in a lump sum. I have elected the above selected settlement option.

_____

Claimant's Signature Date

*(In the event no option is selected a lump sum will be paid.)*

**American National**
**Life Claims Department**
**Mail Processing Center, P.O. Box 10466**
**Springfield, MO 65808-0466**
**1-800-615-7372**

## Additional Information

1. Payment may be expedited if the policy(ies) is/are sent with the completed proof of death.

2. You should send a Certified Death Certificate. The Company reserves the right to require statements by all physicians who treated the insured.

3. Newspaper clippings should also be sent if death resulted from other than natural causes. If an inquest was held by a Coroner or other Legal Official, a copy of the findings should be submitted.

4. The last designated beneficiary or beneficiaries must submit a completed claim form. The following should be observed:

   (a) Each beneficiary must submit a claim form.

   (b) If the proceeds are payable to the estate, the claim must be executed by the executor or administrator of the insured's estate. A certified copy of the Court Order appointing the executor or administrator must also be submitted. Be sure that the Tax Identification Number of the Estate is listed rather than the Social Security Number of the person completing the form.

   (c) If the beneficiary is a minor or a mentally incompetent person, the claim should be executed by the guardian or conservator of the estate of the minor or incompetent person. A certified copy of the court appointment must also be submitted. Be sure that the Social Security Number of the beneficiary is listed rather than the Social Security Number of the guardian or conservator.

   (d) If the policy(ies) has/have been assigned, or a power of attorney or other instrument affecting title to the insurance has been executed, the original or a certified copy of such instrument must be enclosed. The Company may require proof of the interest of any assignee.

   (e) If the proceeds are payable to a Trust, the Trustee or Successor Trustee as provided for in the agreement must complete this form. Include a copy of the Trust Agreement and any amendments with your claim. Be sure that the Tax Identification Number of the Trust is listed rather than the Social Security Number of the Trustee or person completing the form.

   (f) Be sure to include the beneficiary's date of birth.

   (g) If a beneficiary is deceased, please submit a certified copy of the Death Certificate or other satisfactory proof of death.

Please check to see that all questions on the form are answered. Be sure that it is properly dated and signed in all required sections. If you have any questions write to the above address, or call the toll free number listed above.

## Claim Fraud Warnings

Please refer to the applicable fraud warning for your state of residence

**Alabama, Arkansas, Arizona, Louisiana, New Mexico, Rhode Island, Texas and West Virginia:**

**This warning is required by law to be provided on this form and it is for your protection**. 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 restitution, fines and confinement in prison.

**Alaska, Kentucky, Minnesota, Ohio and Pennsylvania:**

**This warning is required by law to be provided on this form and it is for your protection**. A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

**For your protection Colorado law requires the following to appear on this form**. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**Delaware, Idaho, Indiana and Oklahoma:**

**This warning is required by law to be provided on this form and it is for your protection**. Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**For your protection District of Columbia law requires the following to appear on this form**. WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the Applicant.

**For your protection Florida law requires the following to appear on this form**. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Maine, Tennessee, Virginia and Washington:**

**This warning is required by law to be provided on this form for your protection**. WARNING: It is a crime to knowingly provide false or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Maryland:**

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Hampshire:**

Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**For your protection New Jersey law requires the following to appear on this form**. Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**For your protection Puerto Rico law requires the following to appear on this form**. Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.