

MEDICO LIFE INSURANCE COMPANY

**Omaha, Nebraska**

**CLAIMANT'S STATEMENT**

INFORMATION REGARDING THE DECEASED POLICYHOLDER:

NAME OF DECEASED: \_\_\_\_\_

ADDRESS OF DECEASED: \_\_\_\_\_  
Street Number

\_\_\_\_\_ City State Zip

POLICY NUMBER: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

AGE AT DEATH: \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

INFORMATION REGARDING THE BENEFICIARY:

NAME OF FUNERAL HOME: \_\_\_\_\_

NAME OF BENEFICIARY: \_\_\_\_\_

ADDRESS OF BENEFICIARY: \_\_\_\_\_  
Street Number

\_\_\_\_\_ City State Zip

PHONE NUMBER: \_\_\_\_\_

DEATH CERTIFICATE ATTACHED? YES  NO   
(If death certificate not attached, please show the name of the county and state where it can be procured.)

\_\_\_\_\_  
SIGNATURE OF CLAIMANT

\_\_\_\_\_  
ADDRESS

Please return this claim form to: Medico Life Insurance Company, 1515 South 75th Street, Omaha, Nebraska 68124-1618