P.O. Box 10386
Des Moines, IA 50306-0386
Toll Free 1-800-228-6080

Proof of Death

(For Life Policies Only)

Submitted To Medico Insurance Company and/or Medico Life and Health Insurance Company (the "Company").

The furnishing of this form and investigation of the claim is not to be construed as an admission of the validity of any claim or as a waiver of any condition of the policy by the Company.

Instructions for Furnishing Proof of Death

1. Complete **Parts I, II and IV**. If the policy has been in force less than two years or has lapsed within two years from the date of death, you must also complete **Part III.**

2. Enclose a certified copy of the Insured's Certificate of Death that includes the cause and manner of death.

3. If any primary beneficiary has died before the Insured, enclose proof of the beneficiary's death: a copy of the beneficiary's death certificate or obituary or a copy of the Insured's obituary if it mentions the beneficiary predeceased the Insured. In such case, the claim should be made by the other beneficiary(ies), or if there are none, by the duly appointed Personal Representative (Executor or Administrator) of the Insured's estate.

4. If the claim is made on behalf of the Insured's estate, enclose a certified copy of the Letters of Administration or the Letters Testamentary, whichever is applicable, and a completed W-9 for the estate. If the Insured's estate will not be probated and the Insured's state of residence permits payment by affidavit in small estates, enclose the completed affidavit. (The affidavit form can be requested from our office.)

5. If a beneficiary is a minor or is legally incompetent, enclose certified copies of legal documents authorizing you to collect funds on behalf of the beneficiary.

6. If there is a claim for accidental death benefits, furnishing a newspaper account, police report, or coroner's verdict can facilitate the claim.

Mail the completed Proof of Death form and all other necessary documents to:

Medico
Attention: Life Claims
P. O. Box 10386
Des Moines, Iowa 50306-0386

Medico Insurance Company administers for Ability Insurance Company
Medico Life and Health Insurance Company administers for Pioneer Mutual Life Insurance Company

Claimant's Statement
(Please Print All Information)

PART I – The Deceased

Full Name _____
First Middle Last

Residence Address _____
Street City State Zip

Date of Birth _____ Date of Death _____
Month Date Year Month Date Year

PART II – Beneficiaries

Additional beneficiaries can be listed on the back of this form.

Name _____ Relationship to Insured _____
First Middle Last

Residence Address _____
Street City State Zip

Social Security # _____ Date of Birth _____
Month Date Year

Name _____ Relationship to Insured _____
First Middle Last

Residence Address _____
Street City State Zip

Social Security # _____ Date of Birth _____
Month Date Year

Name _____ Relationship to Insured _____
First Middle Last

Residence Address _____
Street City State Zip

Social Security # _____ Date of Birth _____
Month Date Year

Each beneficiary must complete a W-9 Request for Taxpayer Identification Number and Certification form. The W-9s should be returned with this Proof of Death form. A W-9 form is enclosed. If more forms are needed, copy the W-9 form so each beneficiary has one.

Part III – Medical Care

Complete this part ONLY if the policy is less than two years old or has lapsed within two years from the date of death.

List the names and addresses of all physicians who attended the deceased and all hospitals and institutions where he/she was treated during the last illness and during five years prior to his/her death. If you need more room for this information, you can use the back of this form.

Physician/Facility Name _____

Address _____
Street City State Zip

Treatment Date _____ Disease or Condition _____
Month Day Year

_____

Physician/Facility Name _____

Address _____
Street City State Zip

Treatment Date _____ Disease or Condition _____
Month Day Year

_____

Physician/Facility Name _____

Address _____
Street City State Zip

Treatment Date _____ Disease or Condition _____
Month Day Year

_____

<u>Part IV</u> – Signature and Authorization

These statements are true and complete to the best of my knowledge and belief. I understand that the furnishing of forms by the Company does not constitute an admission that there is any insurance in force.

I authorize every doctor or practitioner who examined or attended _____, deceased, and every hospital or any other institution in which the deceased received treatment to fully disclose to the Company or its duly authorized representative any knowledge or information thereby acquired.

Date _____ , 20 _____

Signature of claimant or beneficiary – **PLEASE NOTE: Signature must be notarized.**

Printed Name _____

Signature _____

STATE OF _____)
) ss
COUNTY OF _____)

On this the _____ day of _____, 20 _____, before me, the undersigned Notary Public, personally appeared _____, known to me to be the person(s) named in and who executed the foregoing instrument, and acknowledged to me that he/she/they executed said instrument as his/her/their free and voluntary act and deed for the uses and purposes therein mentioned.

_____

Print Name: _____

Notary Public in and for the state of _____

My commission expires: _____

(Affix Seal or Stamp, if any)

Return to: **Insurance Processing Center**
P.O. Box 1, Des Moines, Iowa 50306-0001 *(Home Office Use Only)* Acct: Dept:

Substitute Form W-9 Request for Taxpayer Identification Number & Certification (2014)

We are required by law to obtain this information when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to 28% Federal income tax backup withholding and you may be subject to a $50 penalty imposed by the Internal Revenue Service under Section 6723.

Complete and return this form. Do not use or photocopy an IRS W-9.

Please Print

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
❒ Individual/sole proprietor ❒ C Corporation ❒ S Corporation ❒ Partnership ❒ Trust/estate

❒ Limited liability company. Enter the tax classification (C=C Corporation, S=S Corporation, P=Partnership) _____

❒ Other (see instructions) _____

Exemptions (see instructions):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, State, and ZIP code

Policy number(s)

Part 1: Taxpayer Identification Number (TIN):

Enter your TIN on the appropriate line. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). For a resident alien who is not eligible to get a SSN, your TIN is your IRS individual taxpayer identification number (ITIN). If you are a sole proprietor and you have an employer identification number (EIN), you may enter either your SSN or your EIN, but the IRS prefers that you use your SSN. If you are a single member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). For other entities, it is your employer identification number (EIN).

Social Security Number:

			—			—				

Employer Identification Number:

		—							

Part 2: Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person - defined in the instructions.
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. **The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.**

Signature of U.S. Person: _____ ***Date:*** _____

Please complete the following areas so we may contact you if we have questions regarding the information you provided.

Person completing this form (Print): _____ Phone: (_____) _____

E-mail Address: _____ Fax #: (_____) _____

For more information or instructions, please refer to www.IRS.gov or contact our office at the number on the accompanying letter.