SOUTHERN PIONEER LIFE INSURANCE COMPANY
PO BOX 64270, ST. PAUL, MN 55164-0270
PHONE 1-800-482-9260 FAX 1-800-604-7819

PART 2: Estate Representative: Complete This Section.

(1) **ATTACH A CERTIFIED DEATH CERTIFICATE TO THIS CLAIM FORM.**
We are unable to consider the claim without this necessary certified documentation.

(2) Please list the name, address, and date of birth of the deceased.

Name: ______________________________

Address: ______________________________

Date of Birth: ______________________________

(3) List all physicians who attended to the deceased within the last 5 years, including **family physician**. Please attach additional sheets, if necessary.

Name of Physician/Hospital:	Treated Deceased For (Medical Condition):	Full Address, Including Zip Code:	Telephone Number, Including Area Code:	Dates Deceased Treated With This Medical Care Provider:

(4) List all pharmacies that provided prescription medication(s) to the deceased within the past 5 years.

Name of Pharmacy:	Full Mailing Address and Phone Number:	Name of Prescription/Medication(s) Provided:

(5) Have the courts appointed an Executor/Executrix for the Estate of the deceased? q Yes q No
If YES, please attach copies of this legal documentation. *This will assist in the processing of the claim.*

(6) Please sign and date the authorization below.

I hereby consent and request that employees or representatives of Southern Pioneer Life Insurance Company be permitted to examine and obtain copies of all hospital, medical, and pharmaceutical records of every sort and kind, interview and obtain written reports from doctors, pharmacies, and other attendants regarding all matters relating to examination, diagnosis, care and treatment of the deceased. I further understand that the information requested may contain information regarding HIV testing and/or treatment for AIDS, AIDS Related conditions, drug or alcohol abuse, and/or psychiatric conditions.

A photocopy of this authorization shall be accepted with the same authority as the original.

Signature:______________________________ Date:______________

Please Print Above Estate Representative's Name: ______________________________

Relationship to the Deceased: ______________________________

Address: ____________________ City: ______________ State: ________

Zip: __________

Telephone Number: (____)______________________

NOTICE: 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.