WICHITA NATIONAL LIFE INSURANCE COMPANY
P.O. BOX 369, WEST CHESTER, OH 45071
(800) 522-1625

CLAIMANT'S STATEMENT

Name of Deceased Insured: ____
Last First, MI

Address of Deceased Insured: ____
Street/P.O. Box City, State Zip Code

Marital Status: _____ Married _____ Single _____ Widow _____ Divorced

Date of Birth: ______________________________ Date of Death: ______________________________

Policy Number under which deceased was insured: ____

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PLEASE ENCLOSE THE ORIGINAL POLICY WITH THIS FORM. **IF IT HAS BEEN LOST OR MISPLACED, PLEASE READ AND ACKNOWLEDGE THE FOLLOWING STATEMENT WITH YOUR SIGNATURE. This is to certify that the above policy has been lost or misplaced and I do no know where it is located. To the best of my knowledge, I affirm that it has not been assigned, transferred, hypothecated or encumbered in any many whatsoever. I agree to indemnify the Company against any loss resulting from payment under the original policy with receipt of same and promise to forward the policy to your office should it be found. I further agree that only payment of recovery can be made on this policy.**

____ ______________________
Beneficiary Signature Date

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Name & Address of Physician(s) that have treated deceased within the past 3 years: ________________________________

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The undersigned hereby applies for payment of said insurance in the Wichita National Life Insurance Company and agrees that the written statements and affidavits of all the physicians who attended or treated the insured, and all other papers called for by the instructions hereon, shall constitute and they are hereby made a part of these Proofs of Death and further agrees that the furnishing of this form or any other forms supplement thereto, by said Company shall not constitute nor be considered an admission by it that there was any insurance in force on the life in question, nor a waiver of any of it's right of defenses.

AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical facility, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or medical condition and/or treatment of the insured and any other non-medical information of the insured to give to Wichita National Life Insurance Company or it's legal representative, and any and all such information.

I UNDERSTAND any information obtained will not be released by Wichita National Life Insurance Company to any person or organization, EXCEPT to companies, reinsuring or other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

NOTICE: Information authorized for release may include information on psychosis, drug, alcohol, communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which the decreased may have been treated while a patient here. A photographic copy of this authorization shall be as valid as the original.

I KNOW that I may request to receive a copy of the Authorization. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for two and one half years from the date shown.

WARNING: "Any person who knowing, and with intent to injure, defraud or deceive any Insurer, make any claim for the proceeds of an Insurance policy containing any false, incomplete or misleading information is guilty of a felony."

____ ______________________
Beneficiary's Signature Date

BENEFICIARY INFORMATION:

Relationship to Insured: ____________________________ Beneficiary's SSN: _______________________________ Date of Birth: _______________________

Address: ____
Street/P.O. Box City, State Zip Code Phone #

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COUNTY OF ____________________________________}
}
STATE OF ______________________________________}

BEFORE ME, the undersigned Notary Public, on this date personally appeared _____________________________________ known to me as the person whose name is (are) subscribed to the foregoing instrument, and acknowledged to me that he/she executed same for the purposes and consideration therein expressed, and in the capacities therein stated.

GIVEN UNDER MY HAND AND SEAL OF OFFICE on this____________________ day of ______________________________, 20___________.

____ ____
Signature of Notary Public Notary's Commission Number

My Commission Expires: ____________________________________

(SEAL)