



National Teachers Associates Life Insurance Company

Attn: Claims Department
P.O. Box 2369 ♦ Addison, TX 75001-2369
(972) 532-2100 ♦ (800) 825-5682
FAX: (972) 532-2192

CLAIMANT'S STATEMENT

INSTRUCTIONS FOR FILING PROOF OF LOSS

1. This form is to be completed by the person or persons to whom the policy is legally payable as beneficiary.
2. If the beneficiary is the insured's estate, the statement should be completed by the executor or administrator and a certified copy of the appointment issued by the proper court and bearing the clerk's signature must be furnished.
3. If the beneficiary is not of legal age, a guardian should complete the form and submit a certified copy of the appointment issued by the proper court and bearing the clerk's signature.
4. **A certified copy of the Official Certificate of Death, certified by the issuing agency, must be supplied to the Company.**
5. Return the original Policy with this form.
6. Please **print or type** all information except signatures.

See page 2 for state specific fraud warnings.

INFORMATION CONCERNING THE INSURED

1. Name (Full Legal) _____
2. Date of Death: (Mo., Day, Year) ____ / ____ / ____ Date of Birth: (Mo., Day, Year) ____ / ____ / ____
3. List all NTA Life insurance policies for which this claim is being made: (Provide all letters and numbers)

All policies listed above must be submitted with your claim. If policies are not attached, please explain why:

4. Names, addresses & phone numbers of all physicians who have treated the insured in the past three (3) years: _____

INFORMATION CONCERNING THE CLAIMANT

1. Name (Full Legal) _____
2. Address: (Include street name & number, city, state & zip)

3. In what capacity are you making this claim? _____
4. Your social security number: _____ - _____ - _____ Your relationship to the deceased: _____
5. Your date of birth: ____ / ____ / ____ Male Female
6. Your phone number (in case we need to contact you):
Daytime () _____ Evening: () _____

AUTHORIZATION TO OBTAIN INFORMATION

I authorize you to give National Teachers Associates Life Insurance Company and/or its reinsurers or its agents: (a) all information you have as to illness, injury, medical history, diagnosis, treatment and prognosis with respect to any physical or mental condition of the patient; and (b) any non-medical information about the patient which the Company believes it needs to perform the business functions described. This form will be valid for the duration of the claim. I agree that a copy is as valid as the original.

Signature of Beneficiary / Guardian / Executor _____

Date signed: _____

In **Arizona** for your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, California and Texas, for your protection, require the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

In the **District of Columbia**, 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.

In **Florida**, any person who knowingly and with the intent to defraud any insurance company or other person files a statement of claim containing any false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, a felony of the third degree.

In **Indiana**, and **Oklahoma**, a person who knowingly and with intent to injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information is guilty of a felony.

In **Kentucky**, any person who knowingly and with intent to defraud any insurance company or other person files a 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.

In **Louisiana**, 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.

In **New Mexico**, 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 civil fines and criminal penalties.

In **Ohio**, any person who, with intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

In **Pennsylvania**, any person who knowingly and with intent to defraud any insurance company or other person files and 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 subjects such person to criminal civil penalties.

In **Tennessee**, it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.