PROOF OF DEATH - GROUP

THE FURNISHING OF THIS BLANK 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.

SEE INSTRUCTIONS ON REVERSE SIDE

Sentry Life Insurance Company
Box 8029
Stevens Point, Wisconsin 54481-8029
800-272-0533

GROUP POLICY NO.

ADMINISTRATOR'S STATEMENT

NAME AND ADDRESS OF ADMINISTRATOR

NAME OF DECEASED	SSN	DOB	DATE OF DEATH

AMOUNT OF INSURANCE $	EFFECTIVE DATE	PREMIUM PAID TO DATE MO___ DAY ____ YR _____	LAST DAY WORKED

NAME AND ADDRESS OF POLICYHOLDER

DATE | SIGNATURE OF ADMINISTRATOR'S AUTHORIZED REPRESENTATIVE | TITLE

CLAIMANT'S STATEMENT

FULL NAME OF DECEASED

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

ADDRESS (NO., STREET — CITY OR TOWN — COUNTY — STATE — ZIP)

PLACE OF BIRTH (CITY OR TOWN — COUNTY — STATE)

RELATIONSHIP TO DECEASED AND CAPACITY IN WHICH YOU ARE MAKING CLAIM

LIST ALL OTHER INSURANCE ON THE LIFE OF THE INSURED:

COMPANIES OR ASSOCIATIONS	POLICIES DATED	AMOUNTS OF INSURANCE

Each undersigned hereby makes claim as beneficiary of the insurance described above and agrees that the furnishing of this form or any of the forms supplemental thereto by the Company shall not constitute or be considered an admission by it that there was any insurance in force on the life in question nor a waiver of any of its rights or defenses.

The statements above are true and complete. I/we agree that the Company may rely upon them as part of the proofs of death under the policies numbered above. Any physician or practitioner (including a medical examiner) who has attended the above named deceased Insured, and/or any hospital (including Veteran's Administration Hospital) or other institution in which the deceased Insured was treated or confined, is hereby authorized to furnish to Sentry Life Insurance Company, or its representative, any and all information and records with respect to any illness or injury, medical history, consultations, prescriptions, or treatments pertaining to the deceased Insured. A photocopy of this authorization shall be considered as effective and valid as the original.

Witness _____ **Signed** _____
SIGNATURE OF CLAIMANT

(PRINT) NAME OF CLAIMANT & SOCIAL SECURITY NO.	CAPACITY OR TITLE OF PERSON MAKING CLAIM	CLAIMANT'S AGE LAST BIRTHDAY	CLAIMANT'S RESIDENCE ADDRESS

Warning – Some states require the following to appear on claim forms:

Any person who knowingly and with intent to defraud any insurance company or other person files an 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 (in some states a felony, and in Florida a felony of the third degree), and subject such person to criminal and civil penalties, and in some states imprisonment.

INSTRUCTIONS FOR MAKING A CLAIM

The reverse side of this form must be completed by the party or parties to whom insurance is claimed to be payable as beneficiaries. If there is more than one claimed beneficiary, each should sign the same form or each may complete a separate form. Additional forms will be sent upon request.

If the policy is payable to a minor, the proof of death must be completed and signed by the guardian of the child's estate (property). A certified copy of the court order appointing the guardian of the child's estate is required. Some states allow transfers to minors by other means. Check with your local Family or Probate Court or an attorney.

If the policy is payable to an estate, the proof of death must be completed and signed by the executor or administrator. A certified copy of the court order making the appointment and authorizing the executor or administrator to act for the estate must be furnished.

If the death was due to other than illness or disease, please include any newspaper clippings and Police or Sheriff's Department reports.

The completed form of each claimant or this form signed by all claimants, together with a certified copy of the death certificate, and any other documents indicated above as deemed necessary in the filing of a claim, should be sent directly to Sentry Life Insurance Company, Box 8029, Stevens Point, Wisconsin 54481-8029.