

**PROOF OF DEATH**

Submitted on behalf of:

1. NAME OF INSURED If married female, give maiden name also	1
2. INSURED'S RESIDENT ADDRESS AT DEATH	2
2a. Date of birth	a. _____ Day Month Year
2b. Place of birth	b. _____
3. Date of death	3
3a. Place of death	a. _____ Day Month Year
4. Occupation at time of death	4
4a. Date last worked full time at full pay	a. _____ Day Month Year
5. Cause of Death	5
5a. When did insured first complain or give other indications of last illness?	a. _____
5b. When did insured first consult a physician for last illness?	b. _____
6. List all Physicians who attended the insured during last illness and during three (3) years prior thereto.	6

The undersigned hereby makes claim to said insurance, and agrees that the written statements and affidavits of all physicians who attended or treated the insured and all other papers called for by the instructions herein, shall constitute and they are hereby made part of these Proofs of Death, and further agrees that furnishing of this form, or of any other forms supplemental thereto, by said Company, shall not constitute there nor be considered by it that was any insurance in force on the life in question, nor a waiver of any of its rights or defenses.

Dated \_\_\_\_\_

Claimant \_\_\_\_\_

Relationship to Insured \_\_\_\_\_

Witness \_\_\_\_\_

FCIB Representative

Contact Phone # \_\_\_\_\_

**FOR BANK USE ONLY**

Insured's Certificate Number(s)	1) _____	2) _____	3) _____
Effective date of coverage	_____	_____	_____
Insured's account balance as of date of death	_____	_____	_____
Date of last premium paid	_____	_____	_____
Amount of last premium paid	_____	_____	_____