PLEASE COMPLETE AND RETURN WITH A CERTIFIED COPY OF THE DEATH CERTIFICATE

POLICY NUMBER(S)

DEATH CLAIM FORM

NORTH CAROLINA MUTUAL LIFE INSURANCE COMPANY
P. O. BOX 281709 NASHVILLE, TN 37228

Please check applicable company:
☐ North Carolina Mutual Life ☐ Booker T. Washington

PLEASE PRINT (Failure to complete form will delay claim processing)

A. Name of Insured (Deceased)		Date of Death	
Address	City	State	Zip Code

B. Name of Beneficiary/Claimant	Social Security Number		Age	Phone Number
Address	City	State	Zip Code	Relationship to Insured

C. If you are not the Beneficiary but are claiming the proceeds of the above policy(s) why do you believe you are entitled to the benefits? Please attach copies of any documents that support your claim:_____

D. If Beneficiary is deceased, attach a copy of the death certificate

E. List names of all Hospitals and/or Doctors and give location where any medical treatment or attention was received by Insured during the 3 year period prior to date of death. (If all policies are over 2 years in duration, this section need not be completed)

Hospital/Doctor	Address	City	State	Zip

Acknowledgement:
I/we hereby claim the proceeds of the policy listed above, and certify that the statements given herein are complete and true to the best of my/our knowledge and belief. I/we understand that the furnishing of forms by the company does not constitute an admission that there is any insurance in force. I/we hereby authorize all physicians, hospitals, clinics, or any other persons who have attended or treated the deceased to disclose any knowledge or information relating to the treatment or history of the deceased, and to permit the bearer, representing NORTH CAROLINA MUTUAL LIFE INSURANCE COMPANY to obtain or view a copy of all records pertaining to such treatment or history. A photo static copy of this authorization shall be considered as effective and valid as the original. **I acknowledge that I have read the fraud statement on page 2 of this form.**

Signed at _____ This _____ Day of _____ Year _____

Signature of Claimant _____ Social Security # _____

Signature of other Claimant _____ Social Security # _____