

CAPITAL RESERVE LIFE INSURANCE COMPANY

P.O. Box 57220, Salt Lake City, UT 84157-0220 | Phone: (801) 264-1060 or (800) 574-7117 | FAX: (866) 403-5365

DEATH CLAIMANT'S STATEMENT

Name of Deceased: _____

Deceased's Address: _____

Date of Birth: _____ Date of Death: _____

Place of Birth: _____ Place of Death: _____

Policy Number: _____ Social Security #: _____

Actual Cause of Death: _____ See Death Certificate _____ Type: _____ Accident _____ Suicide _____ Homicide _____ Natural Causes _____

_____ I hereby certify that the policy has been lost or destroyed: _____
(Must be initialed)

The Undersigned declares that the foregoing statements are true, correct and complete to the best of his/her knowledge:

Claimant's Name: _____ Phone Number: _____
(Please Print)

Claimant's Signature: _____ Dated: _____

Social Security #: _____ Relationship: _____

Claimant's Email Address: _____

Claimant's Mailing Address: _____
Address City, State, Zip

Witness to signature above: _____ Dated: _____

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ASSIGNMENT (To be completed by the Beneficiary if he/she desires proceeds to be paid to the Funeral Home or Mortuary.)

Authorization for Payment to Funeral Home or Mortuary

Capital Reserve Life Insurance Company is hereby authorized to pay the named Funeral Home or Mortuary the sum of the proceeds, not to exceed \$ _____ subject to the provisions of the policy, as payment on a funeral for the Insurance under the above listed policy, making available any or all of the following: first call to home or hospital, preparation or preservation, casket, reposing room, professional service, use of chapel, automobile for family, casket coach, cremation, opening and closing of grave, and other services. **A copy of the Statement of Goods and Services is provided.** I hereby make claim for said proceeds. I know of no reason of any nature why I am not entitled to such proceeds and hereby state and represent that I am entitled to the payment thereby, unless I have authorized the payment of proceeds to another party. I hereby agree that the designated Funeral Home or Mortuary may receive such proceeds, which shall be conclusively acknowledged by me that I have received from the Company the sum specified in settlement. Any difference payable between the amount paid to the Funeral Home or Mortuary and the total amount payable, if any, shall be paid directly to me, as beneficiary, in accordance with the terms of the policy. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information is guilty of a crime and may be subject to fines or confinement in prison.

Funeral Home or Mortuary Name: _____

Funeral Home Email Address: _____

Mailing Address: _____
Address City, State, Zip

Federal Tax I.D. #: _____ Phone #: _____

Claimant's Signature: _____ Dated: _____

The undersigned agrees to indemnify and hold harmless said Insurance Company from all cost, actions, losses or damage which it may suffer by virtue of payment of any proceeds under the above described policy(ies) and agrees to join into any litigation concerning the payment of said proceeds and furnish further proofs, if requested.

Acknowledged by: _____ Title: _____

SNL-DCS (07-2020) For Funeral Home or Mortuary