No. 1 Claimant's Statement

1.	Name of the insured (If married woman give maiden name etc)	1.	
2.	Policy / Certificate Number & Sum Assured	2.	Number Sum Assured
3.	a) Date of Death b) Place of Death	3.	a) _____ Day _____ Month _____ Year b)
4.	a) Date of Birth b) Place of Birth	4.	a) _____ Day _____ Month _____ Year b)
5.	a) Occupation at the time of death b) Date last time worked full time full pay	5.	a) b) _____ Day _____ Month _____ Year
6.	a) Cause of Death b) When did insured first complain or give other indication of last illness? c) When did insured first consult a physician for last illness?	6.	a) b) _____ Day _____ Month _____ Year c) _____ Day _____ Month _____ Year
7.	List all physicians who attended the insured during the last illness and during three years prior there to	7.	Name | Address | Dates | Reason
8.	Has insured other life insurance? If so in which companies and for what amounts?	8.	Companies | Policy No. | Policy date | Sum Assured
9.	In what capacity do you claim this insurance	9.	
10.	Who has the Policy/Certificate	10.	
11.	What is your Date of Birth?	11.	

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 hereon, shall constitute and they are hereby made a part of these proofs of Death and further agrees that the furnishing of this form, or of any other forms supplemental thereto, by said company shall be constituted nor be considered by it that there was any Insurance in force on the life in question, nor a waiver of any of its rights or defense.

The undersigned authorize any hospital, physician or other person who attended the insured or any employee to furnish to the ALLIANCE INSURANCE (PSC) or its representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment, copies of all hospital or medical records and copies of all records of employers. The undersigned further agrees and authorizes that a photocopy of this authorization shall be considered as effective and valid as the original.

Dated .....

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(Notarized by)

Claimant Signature .....

Relationship with insured .....

Address .....

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(This statement must be completed before and attested by an officer authorized by law to notarize documents.)