STARMOUNT
Starmount Life Insurance Company, Inc. • The Starmount Building • Post Office Box 98100
Baton Rouge, Louisiana 70898-9100 • (225) 926-2888 • Fax (225) 926-6292 • www.StarmountLife.com

Dear Beneficiary:

We here at Starmount Life Insurance would like to extend our sympathy regarding your loss. We understand this is a difficult time, and we hope we can alleviate any concerns you may have about your life insurance claim. In order to help expedite this claim, please complete and return the following in the enclosed pre-addressed, return envelope:

1. Claimant's Statement
2. HIPAA authorization form
3. Copy of Birth Certificate
4. Copy of Social Security Card
5. Copy of Driver's License
6. Original Policy/Policies (keep a copy)
7. Certified Death Certificate
8. Executor or Power of Attorney of Estate Documentation.

For questions, please call toll-free 1-888-729-5433, extension 2015. Thank you.

Sincerely,

Shawn Loyal

Shawn Loyal
Claims Supervisor

STARMOUNT

PROOF OF DEATH
LIFE INSURANCE CLAIM
CLAIMANT'S STATEMENT

Full Name of Deceased		Physical Address of Deceased	
Social Security # of Deceased - -		Driver's License # of Deceased	Issued In State of
Date of Birth of Deceased / /	Place of Birth	Date of Death / /	Place of Death
Policy Number(s)	Amount(s) $	Occupation at Death	Date last worked / /
CAUSE OF DEATH: Natural ☐ Accidental ☐ Other ☐ Details:		Was the deceased your natural or legally adopted child or grandchild? Yes ☐ No ☐	
Name of Funeral Home	Phone ( )	Address (Street, City, State, Zip)	

List all other names by which deceased was known: _____

When did Deceased first complain of or give other indications of the condition or illness which eventually led to death? ___/___/___

When did Deceased first consult a physician for the condition or illness which eventually led to death? Mo___ Day___ Year___

In last 5 years, Deceased smoked (or chewed tobacco): ☐ 1 pack per day or less ☐ More than 1 pack per day
☐ Did not smoke in the last 5 years

Do you know any reason this claim should not be paid? Yes ☐ No ☐

List each Life, Health, and Accident insurance policy carried by Deceased with other companies (use back of form if necessary):

COMPANY NAME (Health, Medicare or Medicare Supplement Insurance)	INSURANCE POLICY #	POLICY DATE

COMPANY NAME (Life Insurance)	INSURANCE POLICY #	POLICY DATE	INSURANCE AMOUNT	
			LIFE	ACCIDENT

The information above is true and complete. I/we agree that Starmount Life Insurance Company may rely upon this information as part of the proofs of death under the policies numbered above. I am the rightful beneficiary and claim the insurance monies of the Deceased shown above. To the best of my knowledge all statements and information sent by the Deceased to Starmount Life Insurance Company were complete and accurate. I know of no reason why this claim should not be paid, and request the monies be sent. I understand that misstatement of information on this form in order to collect monies not otherwise owed is a felony, and would subject me to criminal prosecution.

Beneficiary Name (Print)	Signature of Beneficiary	Date Signed / /
Beneficiary's Full Address (including street #, apt. #, city, state & zip)		Relationship

Home Telephone Number	Cell or Work Number	Social Security Number	Beneficiary Date of Birth

Fraud Statements:

For residents of California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Connecticut: Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company, presents false, incomplete, or misleading information in support of an insurance application, claim or other benefit is guilty of insurance fraud and may subject such person to criminal and civil penalties.

For residents of Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of a claim containing false, incomplete or misleading information is guilty of a felony.

For residents of District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of North Dakota: 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 and subjects such person to criminal and civil penalties.

For residents of all other States: 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 may be guilty of a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

I, _____ , authorize the medical facilities and doctors listed below and any other entity which has information on the deceased to disclose **THE ENTIRE MEDICAL RECORD** or other records for _____ to Starmount Life Insurance Company for the purpose of processing a life insurance claim.

Name of all physicians or practitioners who attended or prescribed for Deceased within five years preceding death (use back of form if necessary):

Medical Practitioner or Facility	**Address**	**Phone Number**

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager or other medical related facility, insurance company, family member, the Medical Information Bureau, or other organization or person, that has any record of me to give Starmount Life Insurance Company, my legal representative for medical records receipt, or its reinsurers, any such information. This includes knowledge about drug abuse, alcoholism or mental illness, and HIV (Human Immunodeficiency Virus) and/or AIDS (Acquired Immune Deficiency Syndrome) status **(HIV and/or AIDS Reference Not Applicable in CA)**; and, although this information may be protected by government regulation, I allow Starmount to collect it to determine insurability. (In ME, **This authorization excludes disclosure of the results of a test for HIV if the applicant has not developed symptoms of the disease AIDS or ARC. Such tests results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS or ARC.**) I understand I (or my authorized representative) am entitled to a copy of this authorization form and the information obtained; this authorization will expire in 30 months (in MN, 26 months; KS, KY, NH, ND, NE, NM, OK, WV, WY 24 months) **(in VT, This authorization will expire after 24 months or the policy cancellation, termination or surrender date)** (in AZ, 180 days to disclose HIV-related information) from the date of signature, but can be revoked at any time with the applicant's written notification. (In AZ, no adverse underwriting decision shall be made on the basis of any prior positive HIV-related test or tests unless the insurer has verified that the prior test(s) consisted of both a positive screening test such as enzyme-linked immunoassay (ELISA) and a positive supplemental test such as a Western Blot. All such tests used shall be approved and licensed by the Food and Drug Administration and conducted in accordance with the manufacturer's directions for use, including but not limited to the manufacturers' specified interpretation of positivity). from the date of signature, but can be revoked at any time upon my written request. In MN, this authorization is valid as long as the applicant is continually insured with the insurer, or in [26] months, whichever is less. A photo copy is as valid as the original. This information will be used to determine insurability. The treatment, payment, enrollment or eligibility for health benefits is not conditioned on my signing an authorization. I am aware the records may be subject to re-disclosure by the recipient and that re-disclosed information may no longer be protected by federal privacy regulations. I acknowledge receipt of the MIB Disclosure Notice (in VA, and the Accelerated Benefit Rider 98-010 Disclosure Notice). (Redisclosure statements do not apply in NH.) I authorize Starmount Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. (See reverse for fraud statements specific to your state.) **In VT: This authorization excludes the release of previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC by the applicant's family regular attending medical doctor, practitioner or caregiver or any other entity or person possessing this information, including any medical doctor, doctor of osteopathy, physician, health care professional, hospital clinic, medical facility, the Veterans' Administration, the MIB, Inc., employer consumer reporting agencies, other insurance company, or anyone else, with respect to previous test results. The proposed insured is not authorizing the company to forward the results from any new test for HIV antibodies, T-cell counts, AIDS or ARC requested by the company to any outside, non-affiliated company nor to any entity not under specific contract with the company to perform underwriting services.**

⇨ _____

Signature of personal representative or next of kin Relationship Date

⇨ _____

Signature of Beneficiary Date

⇨ _____

Name of Executor or Power of Attorney of Estate (must include court documentation)