



- Transamerica Occidental Life Insurance Company  
P.O. Box 419521, Kansas City, MO 64141-6521
- Transamerica Assurance Company  
P.O. Box 30852, Los Angeles, CA 90030-0852

# Claim Form

In order to process your claim as quickly as possible, we need some information about you and the Insured. Prior to completing this statement, *please read the instructions on the back of this form*. If there is more than one Claimant, each one must complete a separate Claim Form. Please use black ink when completing.

Please attach **one original officially certified Death Certificate for each Insured**.

### A. Information about the Insured: (please print)

1. Policy number(s) under which you are presenting a claim \_\_\_\_\_
2. Insured's full name \_\_\_\_\_ SSN# \_\_\_\_\_
3. Legal residence/address \_\_\_\_\_
4. Date of **Birth** of Insured \_\_\_\_\_
5. Date last worked \_\_\_\_\_ Occupation at Death \_\_\_\_\_
6. Date of Death \_\_\_\_\_ Cause of Death \_\_\_\_\_

**B. Complete This Section Only** if the policy was issued or reinstated within **two years** of the date of death. Also, please return the policy, if possible.

1. When did the Insured first complain of or give other indications of last illness? \_\_\_\_\_
2. When did the Insured first consult a physician for last illness? \_\_\_\_\_
3. Names of all physicians or practitioners who attended the Insured within 5 years preceding death (*attach additional sheet if necessary*).

Name	Address	Dates of Attendance	Condition(s)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### C. Information about the Beneficiary/Claimant: (please print)

1. Your name \_\_\_\_\_
2. Your street address \_\_\_\_\_  
City, State and Zip Code \_\_\_\_\_
3. Your birth date \_\_\_\_\_ Your phone number: day ( ) \_\_\_\_\_ evenings ( ) \_\_\_\_\_
4. Your Social Security No. or Taxpayer Identification No. \_\_\_\_\_  
Account Name if Taxpayer Identification Number provided \_\_\_\_\_
5. Certification - Under the penalties of perjury, I certify that this is my correct tax reporting number, and that I am not subject to backup withholding (*see Instructions on the reverse side*).

**a) If you are subject to backup withholding, then place a check mark in the box .**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

6. Arkansas residents and Florida residents should see "Note" on reverse side of Claim Form.

### Remarks:

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The claimant makes claim to the insurance and understands that the Company may not yet have verified the status of the policy. The Claimant agrees that by furnishing this form, the Company does not admit that any insurance was in force on the life of the deceased and does not waive any of its rights or defenses.

Signature of Claimant	Date
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**Instructions:**

- (1) Each Beneficiary or Claimant is to complete and sign a Claim Form. If any of the beneficiaries named in the certificate or policy are deceased, a certified copy of the Death Certificate of that deceased beneficiary must accompany this form (*only one certified Death Certificate is needed per Insured*).
- (2) If all or any portion of the proceeds are assigned for funeral expenses, we require a) an itemized statement of the total funeral expenses and b) a valid assignment bearing the signatures of all beneficiaries. We will not accept third party (*Factored*) assignments nor can we pay the assignee more than the balance owed to the assignee.
- (3) If the benefits are payable to the Estate or to the Executor or Administrator of the Insured, the Claim Form should be completed by the legally appointed Executor or Administrator. A court certificate of the appointment (***Letters Probate***) must be furnished.
- (4) If the benefits are payable to a minor or a mentally incompetent person, this form is to be completed by the guardian or conservator of their estate. A court certificate of the appointment is to be furnished; otherwise contact the Company for instructions.
- (5) If the benefits are payable to a trust, the trustee should complete the Claim Form and attach a statement that the trust is currently in force and that the trustee is now actively serving thereunder. The trustee should furnish the trust tax identification number and a copy of the trust relating to Trustee/Successor Trustee(s).
- (6) If the policy has been collaterally assigned, the form may be completed by the collateral assignee alone. If the indebtedness secured by the collateral assignment is less than the benefits payable under the policy, the form may be completed by both the beneficiary and the assignee (payment will be by joint check unless otherwise specified).
- (7) Under current federal tax laws, each Claimant is required to provide us with a Social Security or tax reporting number and certify that he or she is not subject to backup withholding. You may be subject to backup withholding if (1) you fail to provide us with your Social Security or tax reporting number, pursuant to Internal Revenue Code ("IRC") Section 3406 (a) (1) (A); or (2) you were notified that you have underreported interest or dividend income or you were required to but failed to file a return which would have included reportable interest or dividend payments, pursuant to IRC Section 3406 (a) (1) (C). If you are subject to these backup withholding rules, we are required to withhold 30% of any reportable interest payments.

**Note:** If my claim settlement qualifies, I consent to having my proceeds deposited into a fully guaranteed checking account, earning interest at competitive rates. All or part of the principal and interest may be withdrawn at any time by writing a check for a minimum of \$250.00. Full information regarding this account, including a supply of free checks, will be provided upon claim approval. **(If you do not want the interest checking account, you may instead choose to have any benefits paid to you by check by requesting that option in the Remarks section.)**

**For your protection various states require the following to appear on this form:**

**Fraud Statement**

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.

**Colorado Claimants:** "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

**Oregon Claimants:** The State of Oregon requires us to advise you regarding any interest which may be payable on life insurance benefits. The proceeds will earn interest at our current deposit rate from the date of death until the date of total payment, unless payment is made within 30 days from the date proofs of death are received by the Company.

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**The cost, if any, of completing claim requirements, is to be borne by the Beneficiary or Claimant.**