NOTICE OF CLAIM FOR DEATH BENEFITS

A. NAME AND ADDRESS OF CREDITOR

B. AGENT CODE EFF. DATE

C. POLICY/CERTIFICATE # ACCT. #

INSTRUCTIONS TO CLAIMANT

1. Complete this form as soon as possible after death of insured.
2. Have nearest next of kin complete reverse side, sign authorization and return to you.
3. When this form is fully completed, attach:
   (a) Certified copy of Death Certificate
   (b) Cancellation Copy of Policy/Certificate
   (c) Copy of Loan Contract
   (d) If MOB, Copy of Ledger Sheet, Note, Authorization Card

PEKIN LIFE INSURANCE COMPANY
2505 COURT STREET, PEKIN, ILLINOIS 61558

CLAIM DIVISION

PROOFS OF DEATH - CLAIMANTS STATEMENT

Full Name of Deceased ____________________ Age on Policy/Certificate ____________________

Address ____________________ Date of Death ____________________

____________________ Soc. Sec. # of Deceased ____________________

Policy/ Certificate #	Loan #	Date of Policy/Certificate	Original Term	Initial Amount of Insurance	Minus Reduction Amount =	Claim Amount
				$	$	$
				$	$	$
				$	$	$

TOTAL CLAIM $ __________

Amount Due Creditor Beneficiary ____________________ $ __________

Balance Due Second Beneficiary ____________________ $ __________

Name and Address of Second Beneficiary ____________________ __________
Relationship

I hereby certify that the answers given above are full and true:

____________________ NAME OF ISSUING AGENCY

____________________ NAME OF CREDITOR BENEFICIARY ON POLICY/CERTIFICATE

____________________ ADDRESS OF ISSUING AGENCY OFFICE

____________________ ADDRESS CITY & STATE

Dated, this ____________________ , 20 __________

Signature ____________________

Title ____________________

Subscribed and sworn to before me this ____________________ day of ____________________ , 20 __________

____________________ SIGNATURE AND SEALOF NOTARY OR JUSTICE

LK 14 (Rev. 09-02)

PEKIN LIFE INSURANCE COMPANY
2505 Court Street
Pekin, IL 61558

TO BE COMPLETED BY THE NEAREST NEXT OF KIN:

1. Deceased's Name: ______________________ Social Security # ______________
   Please list any other names by which insured may have been known. ______________
   (Include maiden name, hyphenated name, nickname, derivative form of first and/or middle name, or alias.)
   Date of Birth __________ Occupation at Death __________ Date Last Worked ________

2. When did deceased first complain or give other indications of this illness?
   ____

3. When did deceased first consult a physician for this illness? ______________________

4. Names and addresses of all physicians who treated the deceased within five years preceding death:

Name	Address	Dates of Treatment	Disease or Condition

5. Names and addresses of all hospitals where deceased was confined:

Names of Hospitals	Address	Dates Confined	Disease or Condition

DATE __________ **Relationship to Deceased** __________ ______________________
(Signature)

TO BE COMPLETED BY THE EXECUTOR OF THE ESTATE:

AUTHORIZATION

Dated at ______________________
______________________, 20 _____

TO WHOM IT MAY CONCERN:

I hereby request and authorize you to furnish to Pekin Life Insurance Company or its representative any and all information you may have concerning ______________________ (deceased) with respect to any illness or injury(s) the named insured may have suffered, medical history, consultations, prescriptions, or treatments and copies of all hospital or medical records pertaining to the above named insured, that the same may be included as part of the proof of death submitted to the Company.

An exact reproduction of this authorization shall be considered as effective and valid as the original. Valid for the duration of the claim. I may receive a copy.

Witness ______________________ **Signed** ______________________
(Executor of Estate)

Address ______________________ Address ______________________

Address ______________________ ______________________