



Transamerica Worksite Marketing  
 P.O. Box 8043  
 Little Rock, AR 72203-8043  
 1-800-251-7254  
 7 a.m. – 5 p.m. CST

Transamerica Occidental Life Insurance Company  
 Transamerica Assurance Company  
 PFL Life Insurance Company  
 Monumental Life Insurance Company  
 Life Investors Insurance Company of America  
**Members of the AEGON Insurance Group**

By furnishing this form, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

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: \_\_\_\_\_
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 with the insured within 5 years preceding death (attach additional sheet if necessary)

Names	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: \_\_\_\_\_
3. Your birth date: \_\_\_\_\_ Your phone Number: day (\_\_\_\_) \_\_\_\_\_ Evenings (\_\_\_\_) \_\_\_\_\_
4. Your Social Security Number or Taxpayer Identification Number: \_\_\_\_\_  
 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: \_\_\_\_\_

Remarks: \_\_\_\_\_

The Claimant makes claim to the insurance and understands that the Company may not yet have verified the status of the policy.

LIFE INVESTORS  
 INSURANCE COMPANY  
 OF AMERICA

MONUMENTAL LIFE  
 INSURANCE  
 COMPANY

PFL LIFE  
 INSURANCE  
 COMPANY

TRANSAMERICA  
 OCCIDENTAL LIFE  
 INSURANCE COMPANY

TRANSAMERICA  
 ASSURANCE  
 COMPANY

I certify that the above statements are true and correct to the best of my knowledge. I authorize any physician, practitioner or any hospital (including Veteran's Administration or governmental medical facility), clinic or other medical or medically related facility, any medical service organization, any insurance company, worker's compensation carrier, Social Security Office or any other institution or organization to provide the Company or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, any medical or other information, requested by it, including information relating to mental illness, use of drugs or use of alcohol concerning this or other illness or injury, so that the same may be included as part of the proof submitted to the Company. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be as valid as the original. This authorization is valid from the date signed for the duration of the claim. I understand that I, or any authorized representative, will receive a copy of this authorization upon request.

Signature \_\_\_\_\_ Date \_\_\_\_\_