

**WARNING STATEMENT**

**Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.**

**PROOF OF DEATH BENEFICIARY'S STATEMENT  
(Policy in Force Two Years or More)**

**GOLDEN STATE MUTUAL LIFE**  
P.O. Box 512332 - LOS ANGELES, CA 90051-0332



**INSTRUCTIONS**

USE OF THIS FORM IS LIMITED to policies that have been continuously in force for more than two years or policies issued under the single Premium or Annuity Plan. For all other policies, including those having Accidental Death Benefits, use Form D3702.

The Beneficiary's Statement must be made by the party or parties to whom the insurance is payable. If Beneficiary is a minor or the Estate of the Insured, the Statement must be completed by the guardian, executor or administrator and certified copy of such appointment must be furnished. If any Beneficiary predeceased the Insured their Certificate of Death must be furnished.

The Funeral Director's Statement on reverse side hereof must be completed.

The policy must be sent to the Company with this Statement.

If the policy contains a Children's Convertible Term Rider it is not necessary to return the policy. If the insured is deceased please furnish statement of all living children, step-children and legally adopted children and dates of birth.

Every question must be distinctly and fully answered. The Company reserves the right to require or to obtain further information should it be deemed necessary.

**If Assignment of Benefits for Funeral Services is desired, please complete and execute on the bottom of this Statement.**

1. Name and Address of Deceased Insured	Name _____ Address _____
2. Marital Status	' Married ' Single ' Widow ' Divorced
3. Date of Birth	Date _____, 20 _____
4. Date of Death	Date _____, 20 _____
5. Policy Number under which Deceased was insured	Policy No. _____ Policy No. _____ Policy No. _____
6. Name and amount of Insurance of all other companies or associations in which Deceased carried life, health or accident insurance.	_____ _____

The undersigned hereby applies for payment of said insurance into Golden State Mutual Life Insurance Company and agrees that the written statements and affidavits of all the 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 any other forms supplemental thereto by said Company shall not constitute nor be considered an admission by it that there was any insurance in force on the life in question nor a waiver of any of its rights or defenses.

Name of Deceased _____	Beneficiary's Signature _____
Beneficiary's Relationship to Deceased _____	Address (No. & Street, City, State & Zip Code) _____
Beneficiary's Date of Birth, if under 21 years _____	Telephone No. _____ Date _____

**ASSIGNMENT OF BENEFITS FOR FUNERAL SERVICES**

I, the Beneficiary of the Policy(s) described above, authorize the Golden State Mutual Life Insurance Company to pay \$ \_\_\_\_\_ and any and all refund of insurance premiums, if so applicable, to \_\_\_\_\_ Funeral Director.  
Date \_\_\_\_\_ Beneficiary's Signature \_\_\_\_\_

**AUTHORIZATION TO OBTAIN AND DISCLOSE MEDICAL INFORMATION**

**I authorize** any physician, medical practitioner, hospital, clinic, dispensary, sanitarium, druggist, medical or hospital service and pre-paid health plans, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, employer, group policyholders, contract holders or benefit plan administrators to release to Golden State Mutual Life Insurance Company, its reinsurers, consumer reporting agencies, or its legal representative any information they may have as to diagnosis, treatment and prognosis of any physical or mental condition including drug and/or alcohol abuse and/or other non-medical information of \_\_\_\_\_, my \_\_\_\_\_ Relationship \_\_\_\_\_, who died \_\_\_\_\_ Date of Death \_\_\_\_\_

**I understand** that any information obtained will be used to determine eligibility for benefits under an existing policy and will not be released by Golden State Mutual Life Insurance Company to any person or organization **except** its reinsurers, the Medical Information Bureau, Inc., and other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or authorized, or as I may further authorize.

**I know** that I may request to receive a copy of this Authorization.

**I agree** that a photostatic copy of this Authorization shall be as valid as the original.

**I understand** that this Authorization shall be valid for the duration of this claim.

Date Signed: \_\_\_\_\_

\_\_\_\_\_  
Print Name of Beneficiary

Relationship of Authorized Person \_\_\_\_\_  
\_\_\_\_\_

**X** \_\_\_\_\_  
Signature of Beneficiary OR Authorized Person's Signature

Signature of Attending Physician \_\_\_\_\_ M.D.

\_\_\_\_\_  
Date

**FUNERAL DIRECTOR'S STATEMENT**  
 (If this Statement is not completed for Items 1,2,3,4 or 5, a Certified Copy of the  
 Certificate of Death must be furnished the Company.)

7. Name of Deceased Insured	
8. Date of Birth	
9. Date and Place of Birth	
10. Cause of Death	
11. Where was the Deceased Buried?	
12. Statement of Funeral Service (To be completed only if policy benefits are assigned to your firm.)	Date of Service \$ _____ Merchandise and Professional Service \$ _____ Cash Advances made on behalf of the Family \$ _____ <div style="text-align: right;">Total</div> \$ _____ Of the Above Total, there remains unpaid \$ _____
The Undersigned Funeral Director declares that the foregoing statements are true, correct and complete to the best of his knowledge and belief and, if benefit are assigned, that he furnished merchandise and services for the funeral of the named Deceased as stated.	
	Name of Funeral Director
Dated	By _____ Title _____
	Address _____
	City _____ State _____ Zip _____

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