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Birmingham AL 35201-2465
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Website: ada.protective.com

# CLAIMANT'S STATEMENT – Plan 104GP

**All fields must be completed. Missing fields will cause delays in handling.**

1. Information regarding the DECEASED

   Full Name: _____

   Date of Birth: _____ Date of Death: _____

2. ADA/Certificate No. _____ Amount you are claiming: _____

3. Claimant's Full Name: _____
   Note - If beneficiary is a trust, please give the complete name and date of the trust.

4. Relationship to deceased: _____

5. What is your (the claimant's) date of birth: _____

6. In what capacity are you claiming (e.g. beneficiary, executor, assignee, trustee, etc.)?

   _____

I hereby declare that the foregoing answers are true and full; that, to the best of my knowledge and belief, I have withheld no material facts from the Company and that the foregoing answers and statements are made with the object of securing payment to me of the proceeds of the above policy. I expressly consent, authorize and direct any physician, surgeon, any law enforcement agency, or any other person who has examined or attended the deceased and every hospital or any other institution to which the deceased has applied for or in which the deceased has received treatment to disclose to the Company or its duly authorized representative any knowledge or information thereby acquired.

**NY Fraud Statement: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

**NOTICE** – Filing a statement of claim containing any false, incomplete or misleading information with intent to defraud or deceive any insurance company is considered to be a felony in some states.

_____ _____

Printed Name of Claimant Signature of Claimant Date Signed

_____ _____

Social Security or Tax ID Number Street Address

_____ _____

Phone Number(s) City State Zip Code

M1335 (Rev 12/14)