Filing an Assurity Death Benefit Claim

This document lists the forms and evidence generally required for submission of a claim for death benefits. This list is not exhaustive and Assurity may require additional documentation including, but not limited to, a confidential information authorization form, copies of trust and/or estate documents, and medical records.

Assurity administers many different plans of insurance. Please consult the contract for specific benefits, definitions, provisions, limitations and exclusions. The insured's contract may include optional riders providing additional insurance benefits. Please contact the Assurity Claims Department at (800) 869-0355, Ext. 4484 to inquire about other potential benefits.

Notification of Death

Notification of a death may be reported to Assurity by calling Assurity Claims at 800-869-0355, Ext. 4484, or by completing the Notification of Death form.

Upon confirmation of beneficiary designations, the beneficiary will be advised of forms and supporting documentation required for review of the claim.

Death Claim Requirements

Request for Proceeds form	The Request for Proceeds form is a document that must be completed by each designated beneficiary. If the named beneficiary is a trust or an estate, the form must be completed by the appropriate trustee or personal representative of the estate.
Certified death certificate	For each death claim, Assurity requires one certified death certificate with a raised seal and listed cause of death.
Original copy of the insurance policy	Assurity asks that the original insurance policy/certificate be returned to our home office.

Assurity® Life Insurance Company
PO Box 82533 • Lincoln, Nebraska 68501-2533

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(800) 869-0355, Ext. 4484 • Fax (800) 869-0368

NOTIFICATION OF DEATH

Policyowner's Name _____ Social Security No. _____
First Middle Last

Deceased's Name _____
First Middle Last

Date of birth ___/___/___ Date of death ___/___/___
(MM/DD/YYYY) *(MM/DD/YYYY)*

POLICY NUMBER(s)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have all of the original policies listed above? ☐ Yes ☐ No

CONTACT PERSON

Name _____ Telephone No. (___) _____
First Middle Last

Address _____
Street address City State ZIP+4

Relationship to the Insured _____

_____ ___/___/___
Signature of Contact Person *Date (MM/DD/YYYY)*

Direct any questions to our claims department at the phone numbers and address shown above.