DIRECTORS LIFE ASSURANCE COMPANY

DEATH CLAIM

Name of Insured:____________________________**Address**:____

Policy Number:____________________**Dated:**_________________**Amount:**_____________________________

Birthdate:________________________

Place of Death:____________________ **Date of Death:**____

Primary Beneficiary:____

The undersigned hereby makes claim to said insurance with DIRECTORS LIFE ASSURANCE COMPANY.

The undersigned hereby authorizes Directors Life Assurance Company ("DLA") to request any information concerning the death of the insured that DLA may deem necessary, pursuant to the authorization on the reverse side of this Claim Form.

CHECK the Documents you have included:

_________Enclosed is the policy or duplicate when available.

_________Attached to this form is a copy of a Certified Certificate of Death.

Signed (Beneficiary):___________________________ **or Signed (Assignee):**_____________________________

Dated at _____________________________ this _______day of __________________, 20_____.

State of _____________________________________, County of _____________________________________

SIGNATURE (Funeral Home Director):____

On this______day of ___________________________, 20_____ personally appeared before me the above named____ who is known to me and who subscribed the foregoing statement before me and made oath that the foregoing answers are each and all complete and true.

Notary Public:___________________________________ My commission expires:________________________

(SEAL)

WARNING

Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete, or misleading information is guilty of a felony.

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