LAFOURCHE LIFE INSURANCE COMPANY

P.O. Box 246 --- Raceland, LA 70394
Phone: (985)537-7537 Fax: (985)537-7573

CLAIMANT'S STATEMENT

Policies under which claim is being made	POLICY NUMBERS	DATES OF POLICIES MO	DAY	YEAR	Address Premiums were last paid:
					Street
☐ ***Check here if additional information is attached.***					City
					State

1. Full name of Deceased:	1(a) Sex: *(opt)*	1(b) Race: *(opt)*

2. Birthplace of Deceased: City State or Country

3. Date of Birth: Month Day Year

4. Date of Death: Month Day Year

5. Place of Death: Street City State or Country

6. Cause of Death: (Give particulars)

6(a) If death was due to accident, suicide or homicide, specify which:

7. Diseases (previous to most recent) Deceased has had: (Give particulars)

8. Name ALL physicians who were consulted by Deceased during last illness	NAME	DATE ATTENDED	ADDRESS *(City, State Zip)*

9. Was Deceased Married? ◯ Yes ◯ No If yes, is widow or widower deceased? ◯ Yes ◯ No If no, give name and age: Name Age

10. Are there any living children of deceased? If so, provide information:	NAME	AGE	ADDRESS *(City, State Zip)*

11.	NAME	AGE IF LIVING	ADDRESS IF LIVING *(City, State Zip)*
Father			
Mother			
Brothers & Sisters			

12. Claimant Information: *(PLEASE PRINT CLEARLY)*

Name Relationship to Deceased Phone Number

Address City, State Zip

I, the undersigned, hereby certify that the foregoing answers apply to the life therefore insured under policies hereinbefore mentioned, and are furnished as part of the proofs of death of the insured under said policies and under its terms and provisions; that I have an insurable interest to the amount insured, and that I will furnish any further proof the Company may demand.

I hereby waive, on behalf of myself or of any person who shall be interested in the policies hereinbefore mentioned, all provisions of law forbidding or restricting any physician or other person who, at any time, attended or examined the deceased from disclosing in the courts of otherwise, any knowledge, information or belief which be thereby required; and I hereby specifically authorize all such persons to freely communicate their knowledge to the Company, if it requires them to do so.

Claimant's Signature: ____________________ **Witness:** ____________________ **Date:** __________

PHYSICIANS, HOSPITALS, CLINICS, DISPENSARIES, SANATORIUMS, DRUGGISTS, EMPLOYERS AND ALL OTHER AGENCIES:

You are authorized to permit Lafourche Life Insurance Company, or its representatives, to obtain or view a copy of all your records pertainin to the examination, treatment, history, prescriptions and employment of ______________________________ *(Deceased)*

my ____________________ *(Relationship)* who died ____________ *(Date)*

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Claimant's Signature: ____________________ **Witness:** ____________________ **Date:** __________

***** Please note: If this form is not signed in the presence of an authorized employee, signatures must be verified by Notary Public.**

Sworn to and subscribed before me this __________ day of

____________________, 20_____.

____
NOTARY PUBLIC

LCS052004

ADDITIONAL INFORMATION FOR CLAIMANT'S STATEMENT

Please Note: This form must accompany original Claimant's Statement (Form #LCS052004) in order to be valid.

POLICY NUMBERS	DATES OF POLICIES		
	MO	DAY	YEAR

Additional Info/Comments:

LCS052004b