

CLAIM FORM

To claim "Additional Benefits" hereunder the claimant must certify that the insured was not a white person. If the insured was white you are not entitled to any benefits and you may not submit this application.

Name of Insurance Company:

Claim for Additional Benefits under Regulatory Settlement

Name of Claimant	Home Phone: ()	Work Phone: ()
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Address (include City, State, and ZIP)

Claim for Increased Death Benefits

If you are claiming increased death benefits as a policyholder of a policy which is in force please provide as much of the following information as possible:

Name of Policyholder	Policy Number	Social Security # of Policyholder
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Name of Insured (if different from Policyholder)	Date of Birth of Insured
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Address of Policyholder (include City, State, and ZIP)

Date on which Policy was issued	Face amount of Policy	Relationship of Claimant to Policyholder (if different)
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Please attach any supporting documents you may have, such as correspondence with the Company, check vouchers, premium receipt books, etc.

Claim for Additional Death Benefits

If you are claiming additional death benefits as a beneficiary (or the heir of a deceased beneficiary) of a policy under which a death claim has already been filed and a death benefit has already been paid, please provide as much of the following information as possible:

Name of Insured	Date of Birth of Insured	Policy Number	Social Security # of Insured
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Address of Insured at time of death (include City, State, and ZIP)

Name of Beneficiary	Relationship of Claimant to Beneficiary	Social Security # of Beneficiary
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Amount of Death Benefit	Claim No.	Date on which original death benefits were received
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Please attach any supporting documents you may have, such as premium receipt books, correspondence with the Company, check vouchers, copies of insured's death certificate, etc.

Claim for Additional Surrender Benefits

If you are claiming additional surrender benefits as a policyholder (or the beneficiary of a deceased policyholder) of a policy which has already been surrendered and a surrender benefit has already been paid, please provide as much of the following information as possible:

Name of Policyholder	Policy Number	Social Security # of Policyholder
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Address of Policyholder at time of surrender (include City, State, and ZIP)

Name of Insured (if different from Policyholder)	Date of Birth of Insured	Relationship of Claimant to Policyholder
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Date on which Policy was surrendered	Amount of Surrender Benefit received	Date received
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Please attach any supporting documents you may have, such as correspondence with the Company, check vouchers, premium receipt books, etc.

The Claimant hereby certifies that the person whose life is/was insured under the policy described above is/was (check one):

African-American Native American Other non-white: (Describe) _____

Our ability to identify the policy under which you are claiming benefits is dependent upon the amount of information we have. It is therefore in your best interest to supply as much of the information requested in this form as possible, and to furnish a much supporting documentation as possible.

Fraud Warning: In many states, presenting a false or fraudulent claim for the payment of benefits is a crime, subject to civil and/or criminal penalties. See the attached list for the required fraud warning for your state.

I hereby represent that the above information is true and correct to the best of my knowledge and belief.

_____	_____
Date	Signature of Claimant

Be sure to sign this form. We cannot process this form without your signature. Send the completed, signed form, together with all supporting documentation to the following address: [Insert Name of Insurer], P.O. Box 410288, Kansas City, MO 64141-0288.