North American Company
for Life and Health Insurance
Since 1886

Clear Form Clear Kit

O-2818-2

PART TWO - To be completed, in full, signed and dated IF:

- **Death has occurred within the contestable period**
- **Accidental Benefits are being claimed**
- **Death occurred outside of the United States**

A Claim HIPAA Authorization (form O-2722) must be completed and submitted along with any additional documentation listed on the Instructions page.

Name of Deceased	Deceased driver's license number/State Issued	Date deceased first consulted a physician for last illness / /
Date of Accident/Incident / /	Location of Accident/Incident	
Deceased's Occupation	Name, Address and Phone Number of Employer	
Did the deceased ever use tobacco in any form? ☐ Yes ☐ No	If Yes, date last used: From _____ To _____	

Names and addresses of **all** physicians (include personal physician) who attended to deceased and hospitals where treated for past **(10) ten** years. (PLEASE PRINT)

Name	Address	Telephone / Fax Numbers	Disease or Condition
	(Street)	Phone: ( )	
	(City, State, Zip)	Fax: ( )	
	(Street)	Phone: ( )	
	(City, State, Zip)	Fax: ( )	
	(Street)	Phone: ( )	
	(City, State, Zip)	Fax: ( )	

List **all** Life and Health insurance of the Deceased

Company	Policy Number(s) and Amount(s)	Policy Issue Date(s)

I hereby certify that the information provided above is complete and true. I acknowledge that I have read the Fraud Notices included with this packet.

SIGNATURES

Signature of Next of Kin or Authorized Representative	Telephone Number ( )	Date
Address *(Street)*	Witness Signature	
(City, State, Zip)		

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