Foresters Life Insurance and Annuity Company
Life Insurance Claimant's Statement

Foresters Financial

CLAIMS DEPARTMENT . Raritan Plaza I, P.O. Box 7836 . Edison, New Jersey 08818-7836 . 1-877-815-8097 .

SECTION A.

Name Of Deceased	Contract Number(S)	Amount(S)
Residence Address	City	State And Zip Code
Date Of Birth	Source From Which Birthdate Obtained (Birth Certificate, Town Records, Etc)	Place Of Birth
Date Of Death	Cause Of Death	Place Of Death
Other Life, Sickness or Accident Insurance in force at time of death. Names of Companies and Amounts.		

SECTION B.

If death occurred during the contestable period of the policy, please complete this section. List all physicians or hospitals who treated or attended the insured during the past 5 years.

DOCTOR OR HOSPITAL	ADDRESS	DURATION	
		FROM	TO

SECTION C.

I hereby make claim to Foresters Life Insurance and Annuity Company and agree that the written statements and affidavits of all physicians who attended or treated the deceased and all other papers called for by the company shall constitute and are
hereby made part of these proofs of death, and further agree that the furnishing of this form or any forms supplemental thereto by the company shall not constitute, nor be considered, an admission by it that there was any insurance in force on the life of the person in question nor a waiver of any of its rights or defenses.

I certify that the Taxpayer Identification Number (Social Security Number) shown on this form is correct.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____ Claimant's Printed Name

_____ Claimant's Street Address

_____ City

_____ State

_____ Zip Code

_____ Claimant's Signature

_____ - _____ - _____ Claimant's Social Security/TIN #

_____ Claimant's Date of Birth

_____ Claimant's Telephone #

Dated at _____ City _____ State this _____ Day _____ day of _____ Month _____ Year.

REFER TO THE INSTRUCTIONS PAGE FOR ASSISTANCE IN COMPLETING THIS FORM