

LIFE INSURANCE AFFIDAVIT

Nippon Life Insurance Company of America
 P.O. Box 2312
 Mt. Clemens, MI 48046
claims-lifeanddisability@nipponlifebenefits.com
 Phone: 800-374-1835
 FAX: 847-615-3122



Name of Deceased _____	Group Policy Number _____	SS # _____
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NOTE: This affidavit is to be used whenever no beneficiary was designated or no designated beneficiary survives the deceased. A separate form is to be completed by each person within the first of the following classes of successive preference beneficiaries of the deceased which has a surviving member: (1) widow or widower (2) children (3) parents (4) brothers or sisters (5) executor or administrator.

State or Province of _____ County of _____
 Social Security # _____

I, _____, residing at _____
(Street) (City or Town) (State or Province)

being first duly sworn, depose and state:

WIDOW OR WIDOWER	That I am the surviving spouse of the deceased person named above. The date of my birth is _____ Signature _____
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CHILDREN NATURAL OR ADOPTED	That the deceased person named above left no surviving spouse; that I am a child of the deceased; and that the deceased left no surviving children other than myself and those listed below; and I understand that any benefits paid will be paid in equal shares to each of the surviving members of this class:															
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:35%;">Name</th> <th style="width:40%;">Address</th> <th style="width:25%;">Birth Date</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Name	Address	Birth Date												
Name	Address	Birth Date														
	The date of my birth is _____ Signature _____															

FATHER AND MOTHER	That the deceased person named above left no surviving spouse or child; that I am a parent of the deceased; and that the other parent is listed below; and I understand that any benefits paid will be paid in equal shares to each of the surviving members of this class:						
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:35%;">Name</th> <th style="width:65%;">Address or Date of Death</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Name	Address or Date of Death				
Name	Address or Date of Death						
	The date of my birth is _____ Signature _____						

BROTHER(S) AND/OR SISTER(S)	That the deceased person named above left no surviving spouse, child or parent; that I am the brother/sister of the deceased and that the deceased left no surviving brothers or sisters other than myself and those listed below; and I understand that any benefits paid will be paid in equal shares to each of the surviving members of the class:												
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:35%;">Name</th> <th style="width:40%;">Address</th> <th style="width:25%;">Birth Date</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Name	Address	Birth Date									
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	The date of my birth is _____ Signature _____												

EXECUTOR OR ADMINISTRATOR	That the deceased person named above left no surviving spouse, child, parent, brother or sister; and that I am executor or administrator of the estate of the deceased. Submit a copy of the Administration Papers or a Small Estate Affidavit. Signature _____ Date of Birth _____
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It is further understood and agreed that in consideration hereof and as an inducement to Nippon Life Benefits to make payment of the benefits under this coverage Affiant on behalf of himself or herself and on behalf of any surviving members of Affiant's class of surviving preference beneficiaries and any heirs, executors, administrators and assigns hereby releases and forever discharges Nippon Life Benefits, its successors and assigns from any and all actions, causes of action, claims and demands they may now have or may hereafter have against Nippon Life Benefits on account of this insurance policy or arising from any matter in connection with said policy. Further Affiant agrees to save and keep harmless Nippon Life Benefits from any and all claims that may be made against Nippon Life Benefits by the Estate and the executors and administrators or the heirs of the deceased or any other claimant on account of said insurance policy or on account of payment of the proceeds as provided herein.

Subscribed and sworn to before me this _____ day of _____, 20 _____.

Notary Signature _____ Notary Public or other official authorized to administer oaths,

101806-16 (Seal) My commission or term expires _____

Notice Requirements

Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form 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. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: 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 any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: 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 subjects such person to criminal and civil penalties.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.