Proof of Death

American General Life Insurance Company
The United States Life Insurance Company in the City of New York

Service Center: P.O. Box 818100, Cleveland, OH 44181

USE THIS FORM ONLY WITH CLAIMS FOR
NATURAL DEATH BENEFITS OF $50,000.00 OR LESS ON INCONTESTABLE POLICIES

To be completed by licensed practicing Physician, Coroner, or Funeral Director

I certify that _____ , Social Security Number _____ , the Insured/Beneficiary named in policy_____ died on_____ , _____ . The date of birth is _____ , _____ . This person died at _____ . The principal cause of death was_____

Date _____

X

Physician-Coroner-Funeral Director
(Strike out titles not applicable)

_____
Print Name

X

Witness Signature

_____
Address

_____
Print Witness Name

_____
City State Zip Code

Phone # _____

Phone # _____