



**Proof of Death**

**American General Life Insurance Company**  
**The United States Life Insurance Company in the City of New York**  
*A member of American International Group, Inc. (AIG)*  
Service Center: P.O. Box 650253, Dallas TX 75265-0253

**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 # \_\_\_\_\_

