

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 818008, 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 # _____