DEATH CLAIM ADMINISTRATION FORM

ING USA Annuity & Life Insurance Company
c/o Kanawha Insurance Company, Administrator
P.O. Box 2000, Lancaster, South Carolina 29721-2000

FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM:
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.

PLEASE RETURN ALL POLICIES WITH THIS FORM AND ATTACH A CERTIFIED COPY OF THE DEATH CERTIFICATE.

Part 1

I hereby make claim for the death benefits under Policy Number____________________on the life of

____
(Full Name)

insured by the Kanawha Insurance Company.

Deceased's date of BIRTH____________________Date of DEATH____________________

Place of death ____
(if in hospital, give name and address of hospital)

Cause of death____

State your relationship to Deceased____________________YOUR date of birth____________________

Your Social Security Number____

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is subject to prosecution and punishment for insurance fraud.

Part 2

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that in furnishing these forms, the Company does not acknowledge liability or waive any of its rights or defenses.

Witness my Hand at____________________this________day of____________________, 19________

____
Signature of Agent/Notary Public

____
Signature of Beneficiary

____
Address

____
City State Zip

Part 3

Authorization To Release Information:

I hereby authorize any physician, hospital, pharmacy, employer, dentist, coroner/medical examiner, law enforcement agency, insurance organization, consumer reporting agency, or other person or entity possessing any medical information, any information about insurance policies/benefits, or any other information to release all information to Kanawha Insurance Company. This includes any drug, alcohol, psychiatric, HIV infection or AIDS related treatment. A photocopy shall be as valid as the original. The authorization is valid 6 months from the date signed.

Date	Signature	Address

If signed on behalf of another, give relationship:______________________________