5STAR LIFE INSURANCE COMPANY

GROUP INSURANCE DEATH CLAIM FORM

TO AVOID DELAY IN SETTLEMENT,
THIS FORM MUST BE COMPLETED IN ITS ENTIRETY.

PART I - STATEMENT OF GROUP POLICYHOLDER/EMPLOYER

NAME OF DECEASED		DATE OF BIRTH	GROUP POLICY NUMBER
			GNG-MS-040113
SOCIAL SECURITY NUMBER	AMOUNT OF INSURANCE	DATE OF DEATH	PLACE OF DEATH

Was coverage continued to date of death on premium paying basis? ____Yes _____No.
If No, on what date was coverage terminated?_____.
Was death due to occupational accident?_____ Yes _____ No.

National Guard Association of Mississippi
Group Policyholder/Employer

_____ _____
Date Signature

PART II - STATEMENT CLAIMANT

NAME OF CLAIMANT		RELATIONSHIP TO DECEASED
NAME OF DECEASED		DATE OF DEATH
ADDRESS OF DECEASED		
Are you the beneficiary? ____ Yes ____ No	SOCIAL SECURITY NUMBER OF BENEFICIARY	BENEFICIARY'S DATE OF BIRTH
ADDRESS OF BENEFICIARY		
IF THE CAUSE OF DEATH WAS ACCIDENTAL, PLEASE GIVE DETAILS		

_____ _____
DATE SIGNATURE OF CLAIMANT

Please return this form, along with a "Certified" Death Certificate to:

National Guard Association of Mississippi
P.O. Box 627
Jackson, MS 39205

PART III - STATEMENT OF ATTENDING PHYSICIAN - *Complete only if Death Certificate is not available*

NOTE: The medical certification follows the recommendations of the World Health Assembly made in Geneva on July 24, 1948. It has been accepted by all states in this country and in Canada. In the interest of accurate vital statistics, please conform to the Manual of the International List of the Causes of Death.

<table>
<tr><td colspan="2">NAME</td><td>DATE OF DEATH</td><td>AGE AT DEATH OR DATE OF DEATH</td></tr>
<tr><td colspan="2">HOME ADDRESS OF DECEASED</td><td colspan="2">PLACE OF DEATH</td></tr>
<tr><td>CAUSE OF DEATH

ENTER ONLY ONE CAUSE FOR EACH OF (a) (b) AND (c).

* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complication which caused death.</td><td colspan="2">Disease or Condition Directly Leading to Death * (a) _____

Antecedent Causes Due to (b) _____

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Due to (c) _____

Other Significant Conditions contributing to the death but not related to the disease or condition causing death</td><td>Interval Between Onset and Death
_____
_____
_____</td></tr>
<tr><td>SPECIFY _____ Accident
_____ Suicide
_____ Homicide</td><td>PLACE OF INJURY</td><td>DATE OF INJURY</td><td>AUTOPSY

___ YES ___ NO</td></tr>
<tr><td colspan="4">HOW DID INJURY OCCUR?</td></tr>
</table>

These statements are true and complete to the best of my knowledge and belief.

DATE _____

SIGNED _____

(Signature and Degree of Attending Physician)

ADDRESS _____

This statement represents part of the required proofs of death, and any expense incident to its completion must be borne by the claimant.